WELCOME TO MEDICAL SUPER CLINIC

It is essential that your health record contains complete and accurate information to provide quality care. Please assist us by filling out the new patient record form below. Your personal health information is kept private and secure as required by federal and state privacy.

PERSONAL DETAILS

Title Given Name(s)

Surname

Preferred Name (if different to above)

Date of Birth / / | Gender Male Female Other

Address

Suburb | Occupation

Mobile Phone | Home Phone

Email

HEALTH COVER

Medicare Number | Ref | Expiry /

Concession Card CRN | Expiry / /

Card Type Concession Card Pension Card

DVA Number | Card Type Gold White

Private Health Number | Fund Name

NEXT OF KIN

Next of Kin Name | Relationship

Phone Number

Emergency Contact Name (if different to above) | Relationship

Phone Number

BACKGROUND

Do you identify as Aboriginal and/or Torres Strait Islander?

No Yes - Aboriginal Yes – Torres Strait Islander Yes – Aboriginal and Torres Strait Islander

Ethnicity ____

Knowing your cultural background helps us provide health care that meets your individual needs

Have you had a chronic illness for 6 months or longer?

No Yes (please describe)

You may be eligible for discounted or bulk-billed allied health services. Ask your GP or reception about booking a Care Plan today.

CONSENT

Medical Super Clinic Benowa collects information from you for the primary purpose of providing quality health care. Your personal information will only be used for the purposes for which it was collected or as otherwise permitted by law, and we respect your right to determine how your information is used or disclosed. **Please tick the boxes below.**

I understand that there may be a $40 out-of-pocket fee for my consult

I have read and understood the above privacy statement

I consent for my information to be collect and stored by Medical Super Clinic Benowa

Signed ____ Date ______/______/_______

How did you hear about our practice?

Family/Friends Social Media Signage Google HotDoc Other ____________________