NEW PATIENT INFORMATION

Given Name _____ Surname _____

Known as _____ Date of Birth ____/____/_____ Gender:_____

Are you Aboriginal and/or Torres Strait Islander? YES / NO

Country of birth _____

Are you currently an Australian Citizen? YES / NO

Is there any cultural background we should be aware of? YES / NO

If so, please specify _____

Residential Address _____

Suburb & State _____ Postcode _____

Postal Address (if different to above) _____

Phone (M) _____ (W) _____ (H) _____

Please indicate if you would like to receive SMS services (Including but not limited to; appointment reminders, recall alerts, reminders and other services)
***Please note you may opt-out at any time by notifying the practice.**

- ☐ YES, I WOULD LIKE TO RECEIVE SMS SERVICES
- ☐ NO, I WOULD LIKE TO OPT-OUT OF RECEVING SMS SERVICES

Medicare Number _____

Reference Number _____ Expiry date (MM/YY) _____/_____

Commonwealth Concession Card Type Pension / Health Care / Seniors

Entitlement Number _____ Expiry Date _____/_____

Veterans Affairs Card Type Gold / White / Orange

DVA Entitlement Number _____ Expiry Date _____/_____

Emergency Contact

Given Name _____ Surname _____

Mobile / Work / Home _____ Relationship _____

Campbell Medical Practice is fully compliant with all Commonwealth and Territory Privacy Legislation requirements. To obtain a copy of our privacy policy, please ask at reception or, alternatively, it is available on our website.