ATHERFIELD MEDICAL SERVICE

PATIENT INFORMATION FORM

Dear Patient

Thank you for taking the time and trouble to complete this form. If any personal details change in future, please let our receptionists know.

Mr/Mrs/Ms/Miss/Other..... Gender Male/Female/Other.....

First name: ..... Middle Name: ..... Surname: .....

Date of birth: ..... Occupation: .....

Residential address: .....

Postal address: .....

Email address: .....

Telephone Number(s): Home: ..... Mobile: ..... Work: .....

Consent to SMS reminders: Yes ☐ No ☐ If Yes, mobile Number for SMS reminders: .....

Ethnicity:
☐ Australian, non indigenous
☐ Aboriginal, but not Torres Strait Islander
☐ Torres Strait Islander, but not Aboriginal
☐ Both Aboriginal and Torres Strait Islander
☐ Other (Please specify): .....

Please tick below if you hold any of the following concession cards. **If so, please also show them to the receptionist when you hand back this form so the card number/expiry date details can be added/updated on your record:**

☐ Pension Card
☐ DVA Card
☐ Health Care Card
☐ Seniors Health Card
☐ Medicare Card Medicare No: ..... IRN: ..... Expiry: .....

Are you in a private health fund? Yes ☐ No ☐ If yes, Name of fund? .....

Next of Kin:

Title (Mr/Mrs/Ms/Miss): .....

First Name: .....

Surname: .....

Address: .....

City/Suburb: ..... Postcode: .....

Relationship: .....

Telephone No(s): Home: ..... Mobile: ..... Work: .....

Emergency Contact: Same as Next of Kin? Yes ☐ No ☐ **If YES, please complete Patient Signature, Today's Date, & Patient Name below** **IF NO, please turn over and complete Page 2 (Emergency Contact)**

Patient Signature: ..... **Date:** .....

Patient Name: .....

Office Use Only: **Patient ID Confirmed (please sight drivers license) (Staff Initials): .....**

Office Use Only: Information input into Best Practice (Staff Initials): .....

NOTE: ONLY COMPLETE EMERGENCY CONTACT IF DIFFERENT FROM NEXT OF KIN

Emergency contact: Title (Mr/Mrs/Ms/Miss): .....

First Name: .....

Surname: .....

Address: .....

City/Suburb: ..... Postcode: .....

Relationship: .....

Telephone No(s): Home: ..... Mobile: ..... Work: .....

Patient Signature: ..... **Date:** .....

Patient Name: .....