





**EMERALD LAKES MEDICAL CLINIC**  
**NEW PATIENT REGISTRATION FORM**

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Mr  Mrs  Ms  Miss  Master  Other

Single  De-facto relationship  Married  Separated  Divorced  Widowed

First Name _____ Middle Name _____ Surname _____	
<b>Date of Birth:</b> ____/____/____ <b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other	
Medicare Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Ref <input type="text"/> Expiry ____/____
Concession Card <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	HCC <input type="checkbox"/> PEN <input type="checkbox"/> Expiry ____/____
DVA Card No: _____ Gold / White: _____ Expiry ____/____	
<b>Home Address:</b> _____	
<b>Suburb:</b> _____ <b>Post Code</b> _____	
<b>Mobile No</b> _____ <b>Home No</b> _____ <b>Work No</b> _____	
<b>Email address</b> _____ <b>Occupation</b> _____	
<b>Private Health Insurance:</b> No <input type="checkbox"/> Yes <input type="checkbox"/> Type of Cover: Top <input type="checkbox"/> Intermediate <input type="checkbox"/> Basic <input type="checkbox"/>	

<b>Country of Birth</b> _____ Year arrived in Australia if born overseas _____	
<b>Cultural Background (Family Heritage)</b> _____	
<b>Do you identify as</b> Aboriginal  <input type="checkbox"/> Torres Strait Islander  <input type="checkbox"/> or both  and  <input type="checkbox"/>	
Is English your primary language <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other languages spoken _____ is an interpreter required <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Next of KIN Contact Details</b> <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	
First Name _____ Surname _____ Relationship _____	Contact No _____
<b>EMERGENCY Contact Details</b> <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	
First Name _____ Surname _____ Relationship _____	Contact No _____

**PATIENT CONSENT**

I understand that this practice undertakes professional development to improve patient care.  
I consent to the use and disclosure of my personal health information to any health care providers involved in my medical treatment and health care.  
As part of preventative health services offered by this practice, we send appointment reminders and recalls via SMS when routine investigations are due for continuity of your health care. Referrals are sent electronically via secure method to the appropriate recipient.  
I consent to receive follow up reminders and recalls.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

This practice is committed to ensuring the privacy and confidentiality of all personal information affiliated with Emerald Lakes Medical Clinic if you wish to review this policy please ask at reception.