# PATIENT INFORMATION FORM

We are committed to providing our patients with the best care. To do this, it is essential that your health record is kept up to date and accurate. Please assist by completing below:

Morningside + Belmont General Practice Clinics

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|---|---|---|---|---|---|
| **Title** (please circle) | Mr | Mrs | Ms | Miss | Mast |
| **First Name:** | | | **Middle Name:** | | |
| **Surname:** | | | | **Preferred Name:** | |
| **Date of Birth:** | | | **Gender (please circle):** | Female | Male Other |
| **Medicare Card Number:** **Reference #: (**left of your name) | | | | **Expiry Date:** | |
| **Are you of Aboriginal or Torres Strait Islander origin?** | | | Yes / No | | |
| **DVA (Dept of Veterans Affairs)** | **QX Number:** Type (please circle): Gold / White | | | **Expiry Date:** | |
| **Government Pension** | **Number:** Type (please circle): Aged / PPS / Disability | | | **Expiry Date:** | |
| **Centrelink Health Care Card** | **Number:** | | | **Expiry Date:** | |
| **Street Address** | | | | | |
| **Suburb** | | | | **Postcode:** | |
| **Phone** | Home: | | Work: | | |
| | Mobile: | | I agree to Morningside and Belmont General Practice communicating with me by text message. | Yes / No | |
| **Personal Email** | | | I agree to Morningside and Belmont General Practice communicating with me by email. | Yes / No | |

**Your Health Practitioner may wish to contact you by SMS or EMAIL for health reminders or if you need to follow up with your practitioner for test results. Please be aware that with communication by email we are limited to our control over your privacy.**

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| **Next of Kin** | Full name:<br>Contact number:<br>Relationship to you: | | |
| **Emergency Contact** | Full name:<br>Contact number:<br>Relationship to you: | | |
| **Occupation** | | | |
| **Country of Birth** | | **Spoken Language:** | |
| **Ethnicity** | | **Religion:** | |

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| I confirm that the mobile number held is correct and I will notify the practice of any changes. | Yes / No |
| I am aware that I can withdraw consent at any time by informing the Health Practitioner or the practice either verbally or in writing. | Yes / No |
| I agree that it remains my responsibility at all times to contact the practice regarding tests that have been ordered by my Practitioner. | Yes / No |
| I agree that I am responsible for my financial account and will pay for any private fees. | Yes / No |
| I authorise my guardian/carer/spouse to speak to my Health Practitioner on my behalf. (This authorisation can be withdrawn at any time.)<br>Full Name of guardian/carer/spouse: | Yes / No |

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|---|---|
| **Signature:** | **Date:** |