

New Patient Registration Form

It is our great pleasure to welcome you to the Jindalee Care Medical Practice. We are dedicated to the highest standard of professional care for all our patients. Our aim is to partner you in maintaining your long-term health and well being, This is our commitment to you.

PLEASE PROVIDE AN ANSWER TO ALL QUESTIONS

FIRST NAME	SURNAME	MISS MS MRS	MSTR MR	DR
KNOWN AS				
DATE OF BIRTH (i.e. DD/MM/YY)				MALE / FEMALE
MEDICARE CARD NUMBER		Ref No	Expiry Date	
CONCESSION CARD		Ref No	Expiry Date	
VET AFFAIRS CARD NUMBER		Expiry Date		
RESIDENTIAL ADDRESS				
SUBURB		STATE	POSTCODE	
HOME PHONE		WORK PHONE	MOBILE	
EMAIL ADDRESS				
PLEASE CIRCLE	Aboriginal	Torres Strait Islander	Both	Non Indigenous
MARITAL STATUS				
OCCUPATION				
COUNTRY OF BIRTH				
ETHNICITY (e.g. Caucasian, African, Asian etc.)				

DETAILS OF YOUR NEXT OF KIN

DETAILS OF YOUR EMERGENCY CONTACT

NAME Mr/Mrs/Miss/Ms	NAME Mr/Mrs/Miss/Ms
_____	_____
RELATIONSHIP TO PATIENT	RELATIONSHIP TO PATIENT
_____	_____
HOME PHONE	HOME PHONE
_____	_____
MOBILE	MOBILE
_____	_____

Our practice uses a reminder system to help maintain your health. We provide our patients with preventative care and early case detection reminders e.g. Blood test results, immunisation, annual health checks, skin checks, cervical screening via an SMS system. We also utilise an SMS system for appointment reminders.

I consent to being contacted via SMS with reminders to help me maintain my health. Yes No

Please be aware that you are responsible for following up any results you may have.

Results are NOT given over the phone. You will need to make an appointment with your doctor to receive your results.

Patients Signature or Parent / Guardian: _____ Date: _____