REYNELLA MEDICAL CENTRE

44 Hillier Rd, Morphett Vale, SA 5162

Phone: (08) 382 3900

www.reynellamedical.com.au

NEW PATIENT INFORMATION

MR/ MRS/ MS/ MISS/ MST/ OTHER _____

SURNAME: _____

GIVEN NAMES*: _____

(*as listed on Medicare card)

PREFERRED NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

POSTAL ADDRESS (if different from above): _____

_____

EMAIL ADDRESS: _____

PHONE- HOME: _____ WORK: _____

MOBILE: _____

MEDICARE NUMBER**: _____

EXPIRY: _____ CARD POSITION NO: _____

PENSION NUMBER**: _____

EXPIRY: _____

HEALTH CARE CARD NUMBER**: _____

EXPIRY: _____

VETERAN AFFAIRS NUMBER**: _____

EXPIRY: _____ COLOUR: _____

**may need to be sighted

PRIVATE HEALTH INSURANCE: YES / NO INSURER _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

NEXT OF KIN: _____ PHONE: _____

EMPLOYER: _____ PHONE: _____

MEDICAL HISTORY

SMOKER: YES / NO

COUNTRY OF BIRTH: _____

ABORIGINAL/TORRES STRAIT ISLANDER: YES / NO

ALLERGIES: _____

MEDICAL HISTORY:(operations etc) _____

_____

_____

FAMILY HISTORY:_____

_____

NON PRESCRIPTION MEDICATIONS TAKEN: (ie Aspirin, Fish Oil etc)

_____

_____

WILL THIS BE YOUR REGULAR DOCTOR?: YES / NO

I UNDERSTAND THAT THE CLINIC USES SMS AND EMAIL COMMUNICATION WHERE SUITABLE AND RELEVANT. (PLEASE ADVISE US BELOW SHOULD YOU CHOOSE TO OPT OUT)

I AUTHORIZE THE PRACTITIONER TO ELECTRONICALLY LODGE MEDICARE CLAIMS ON MY BEHALF

SIGNATURE: _____ DATE:_____

PLEASE ALSO SIGN OUR “HEALTH INFORMATION AND USE CONSENT FORM”

EXTRA SPACE IF NECESSARY:

_____

_____

_____

_____