NEW Patient Details Form
Christies Beach Medical Centre

Family Health Care Since 1964
100 Beach Road Christies Beach SA 5165
Postal Address: PO Box 95 Christies Beach SA 5165
Telephone (08) 8384 4444 Facsimile (08) 8384 7374

Family Name: _____

Given Name: _____

Preferred Name: _____

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Mast ☐ Miss

Birth Sex:_____ **Gender Identity**_____

Ethnicity Status

Aboriginal Yes/No Torres Strait Islander Yes/No

Country of Birth: _____

Date of Birth: _____

Postal Address: _____

_____**Post Code**:_____

Contact Phone: _____

Work/ Mobile:_____

Email:_____

Medicare No.:

_____**exp**_____

Veteran Affairs No.:

_____ **exp**_____

Concession Card.: ☐ HCC ☐ Pension ☐ Student

_____**exp**_____

Next Of Kin Name: _____

Relationship: _____**Ph.:** _____

Emergency Contact: _____

Relationship: _____**Ph.:** _____

SMS Reminders
I consent to being contacted with appointment reminders, recalls and health awareness information.
Please let us know if you do not want this to occur.

Medicare
I authorise the practitioner to electronically lodge Medicare claims on my behalf

PATIENT PRIVACY INFORMATION
please read important privacy information carefully and complete authority

The Christies Beach Medical Centre (CBMC) requires accurate personal information to be collected to ensure your health needs are met, and the associated administrative processes are conducted in your best interest. In some instances information may be shared with other health care providers to ensure the continuity of your health care (e.g. referrals/ Medicare). Risks with electronic communication in that the information could be intercepted or read by someone other than the intended recipient. All information provided to us is held on our premise, in confidence. You have the right to access your medical records if required.

Do you authorise a responsible person to call on your behalf to access your medical records (e.g. test results, immunisation data)?

Yes ☐ No ☐

If so, please print their full name and their relationship to you. Your authorisation does not represent an entitlement for that person to make health care or medical treatment decisions for you.

Name: _____

Relationship:_____

Patient/Parent/Guardian Signature:

_____**Date:**_____