Richmond Medical | South Yarra Medical | Hawthorn Medical

New Patient Details Form

Thank you for registering your details with Richmond Medical & South Yarra Medical (Balanced Medical). Whilst you have provided us with some of your details, please take a moment to complete the rest of the details we require to create your record with us.

Important!!! If you think you may have previously been at this practice (under another name or in the past) please inform the customer service staff prior to completing this form so that duplicate medical files are not created for you.

Personal Details

Title: Dr Prof Mr Mrs Miss Ms Master other

Given Name(s): **Surname:**

Is the name you provided exactly as it appears on your medicare card? Yes No (please circle) If not- we need to ensure this matches otherwise your claim may not be able to be processed- ***please confirm your full name as it appears on these documents.***

Preferred name if different to given name: *I like to be called:*

Date of Birth:_____/_____/________ **Gender**: Male Female Other (please circle)

Cultural Background: Non-Indigenous Aboriginal Aboriginal and Torres Strait Islander Torres Strait Islander Not stated
Other: *(please state)*

Contact Details

Street address:

Suburb: **State:** **Postcode:**

Phone (home): **Mobile:** **Work:**

Email:

Identification Details

Medicare Number: ☐☐☐☐☐☐☐☐☐☐ Ref no: ☐ This is the number next to your name on the card Expiry Date:

HCC/Pension Number: (if applicable) Expiry Date:

DVA Number : (if applicable) Expiry Date:

Do you have an eHealth record? Yes ☐ No ☐ ***If yes, please let your doctor know in your consult***

Notice: *Our practice uses email & SMS for health or appointment reminders. Please tick if you do NOT wish to be contacted in this way. [ ]*
Note we do not provide results, consultation notes or any other medical correspondence via this method.

How did you find us? Patient referral ☐ Internet (Google) ☐ Station Signage ☐ Walked Past ☐ Website ☐

Occupation:

Country of Birth :

Emergency contact person / Next of Kin

Full Name: Contact Number:

Relationship to you:

I give my consent that information regarding my treatment be released to other Specialist practitioners and or other Balanced Medical (South Yarra Medical & Richmond Medical) practitioners as necessary.
Balanced Medical acknowledges and respects the privacy of individuals. The personal information collected is necessary for us to provide you with the best possible service. By completing this form, Balanced Medical accepts that you, your parents/guardians (if person is under 18 years of age) have consented for this information to be collected. The intended recipients of this information are Balanced Medical (and its group practices) and its authorized staff. You have the right to access and alter personal information collected in accordance with the Commonwealth Privacy Act, a copy of our privacy policy is available from the practice.

Consent and agreement
I agree to the terms & conditions of registration with Balanced Medical. For further information refer to our patient information sheet.

Full Name (please print): Date:

Signature: