Welcome to grantstreet gs CLINIC

New Patient Information

Please fill out the following details, taking care to record your name as it appears on your Medicare Card. The information you provide to us is confidential. It is used to correctly identify you within the Practice, in our dealings with Medicare and with other health professionals who are involved in your care. Thank You.

Surname			Mr Mrs Miss Ms	
First Name		Middle Initial		
Date of Birth				
Home Address				
	Town / City		Post Code	
Postal Address				
	Town / City		Post Code	
Phone Contacts	Mobile		Home	
	Work			
Nationality				
Occupation				

To assist with health initiatives, do you identify as being Aboriginal or Torres Strait Islander?

() **Aboriginal** () **Torres Strait Islander** () **Aboriginal & Torres Strait Islander**

() **NON Aboriginal or Torres Strait Islander**

Do you identify with another cultural background? _____

Medicare Number		Ref. No		Expiry Date	
Pension / Health Care Card / DVA Number				Expiry Date	

Name of Next of Kin		Phone	
Relationship to Patient			
Name of person to contact in case of Emergency		Phone	
Relationship to Patient			

Do you have any allergies or are you sensitive to drugs or dressings? () Yes (please list below) () No

Allergy_____ Reaction_____

Grant Street Clinic is a Private Billing Practice.

I agree that I will be responsible for payment of any accounts incurred in my name OR as a result of a third party claim consultation.

Signed			
Print Name		**Date**	

Due to the new RACGP Accreditation Standards, patients' must return for a follow-up appointment for all test results ordered by your Doctor, in order that full discussion and explanation of results is documented and affords opportunity to question the Doctor about your tests. NO RESULTS WILL BE GIVEN OVER THE TELEPHONE.

Office Use only: Entered by: _____