beachside doctors

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New Patient Registration Form

To better understand your health needs, please bring the following to your first appointment:

- Medications
- Available medical records
- Relevant paperwork (example; medical power of attorney, advanced care plan, and/or GP management plans)

Patient Details

Mr/Mrs/Ms/Miss/Dr	Full Name:	
Date of Birth:	Sex: M / F / Other	Phone:
Address:		Suburb:
Medicare No: _ _ _ _ _ _ _ _ _ _- _		Expiry:
Pension/HCC/DVA No:		Expiry:
Do you identify as an Aboriginal or Torres Strait Islander? Yes / No		Your country of birth?
Emergency Contact Full Name:		Phone:
DOB of Emergency Contact (if patient is under 18):		Next of Kin: ☐s above Other (specify)

Patient Consent (please circle)

I am happy to receive SMS for appointments, clinical reminders and results:	Yes	No
I consent to the disclosure of information to those directly involved in my healthcare:	Yes	No
I agree to pay on the day of the consultation:	Yes	No
I would like my medical records transferred from my previous clinic:	Yes	No
Name of Previous Medical Clinic:		

Please return this form in person or email it to info@beachsidedoctors.com.au

Signature:______________________________ Date: __________________

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