New Patient Information

Salutation: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other Date of birth ___ / / ___

First name: ______________________________
Surname: ______________________________
Address: ______________________________
Suburb: ______________________ Postcode: __________
Phone numbers: ______________ Work ______________ Mobile ______________

I wish to receive SMS reminders: ☐ Yes ☐ No

Email address: ______________________________

This is essential so we can send important information to you about your appointment

I wish to receive email reminders: ☐ Yes ☐ No

I wish to receive emails about clinic news and offers ☐ Yes ☐ No

Medicare number ______________ Ref Number (left of your name): ______ Expiry: ___ / ___

Private health insurance ______________ Number ______________

Pension/Health Care Card/Veteran's Affairs No: ______________ Expiry: ___ / ___

Occupation: ______________ Company: ______________

Emergency Contact Name: ______________ Phone: ______________

Emergency contact relationship: ______________________________

GP Doctor Name: ______________ Suburb ______________

If you were not referred by a Dr, how did you find out about our clinic?

☐Other health professional ☐Insurance company/Rehab provider

☐Friend, family, work colleague referral - Name

☐Outside signage ☐Flyer

☐Google ☐Other search engine

☐Facebook Online appointment: ☐Appointuit ☐Other

BJC Health does **NOT** offer account facilities – **all treatments MUST be paid for at the time of consultation**. Excluding approved workers compensation clients.

Should you need to reschedule your appointment, **please inform us at least 24 hours prior** to your appointment time. Broken appointments with insufficient or no notification may incur a fee.

Privacy Notice: *Information collected by us about you will be stored according to the requirements of Federal Privacy legislation. It will only be passed on where appropriate to the care of the medical problem about which you consulted us, or where legally required. Please let us know if you require further information.*

PATIENT DECLARATION: *I have read and agreed with the information contained in this document. All answers and information provided by me are, to the best of my knowledge, correct. Should there be any changes in the future, I will notify the clinic of them as soon as possible.*

The practitioners in this practice will discuss your condition and options for treatment with you so that you are appropriately informed and can make decisions relating to treatment. You may choose to consent to, or refuse any form of treatment for any reason including religious or personal grounds. Once you have given consent, you may withdraw that consent at any time.

During the examination, assessment and treatment it may be necessary for your practitioner to make physical contact. Your practitioner will ask your permission before making physical contact with you in any way.

In the case of insurance claims*, I give my consent for all appropriate, non-confidential information to be released to relevant parties (employers, insurance companies, etc.). Should my claim not be accepted, I understand that I am personally responsible for payment of accounts for treatment(s) received here.*

I hereby give my consent to commence treatment.

Patient Signature: ______________________ **Date:** __________

(If under 18 years of age must be signed by a Parent or Guardian)