New Patient Registration

LIFELINE HEALTHCARE GROUP
YOUR LOCAL HEALTHCARE

Title | First Name | Middle Name

Surname

Birth Sex | Gender Identity

D.O.B (D M Y) | Occupation

Ethnicity | Australian | Aboriginal/Torres Strait Islander | Other

Address

Suburb | Post Code

Contact_Home | Contact_Mobile

Email | Do you consent to SMS? Yes | No

Medicare No | Expiry Date (D M Y) | IRN Number

Insurance Card No | Expiry Date (D M Y) | Patient ID

Pension Card No | Expiry Date (D M Y)

DVA Card No | Expiry Date (D M Y) | Gold | White

Private Health Insurance | Member No

Next Of Kin | Relationship | Contact No

Emergency Contact | Relationship | Contact No

Do you have any allergies to drugs / dressings? Nil Known | Yes | Allergy To

Any Special Medical/Health Requirements: Yes/ No (Please and if yes, specify)

Reaction | Allergy To

Please tick severity of reaction - Mild | Moderate | Serve

Do you have an assistant dog? Yes | No | Ref No

CONSENT: I give permission for my personal health information/ my child's personal health records to be used for administrative purposes to assist in the running of Lifeline Healthcare Group, including disclosure to others involved in my healthcare such as treating doctors, specialists within and outside of this medical practice. This may occur through referral to other doctors, or for medical tests in the reports or results returned to my doctor following referrals. I consent to be part of recall and reminder services, including correspondence and notification via SMS communications.

Print Name _____ Signature _____ Date _____