**KINGS PARK CLINIC**
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Kings Park, SA, 5034
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# New Patient Information Form

**Before you fill in this form, please be aware that;**

1) We are a mixed billing clinic and do not bulk bill unless you show us a *current* DVA card.
2) If you do not attend your appointment or cancel with less than 2 hours' notice, there may be a fee of $50.
3) Payment for your appointment is your responsibility and is due at the conclusion of your appointment.
4) The clinic charges an administration fee to transfer your medical records to another health care provider.
5) Doctors at this clinic do not prescribe, UNDER ANY CIRCUMSTANCES, to patients not known at this clinic or for medications containing pseudoephedrine or opiates.

DR / MR / MRS / MISS / MS / OTHER _____ **Surname:** _____

**Given names:** _____ **Preferred name:** _____

**Date of birth:** _____ **Gender:** _____ **Pronouns:** _____

So we can give you the appropriate medical care; do you identify as someone from a culturally and/or linguistically diverse background: YES / NO **IF YES: which one:** _____ **& do you require an interpreter** YES / NO

To assist with health initiatives - **Do you identify as an Aboriginal or Torres Strait Islander:** YES / NO

Aboriginal YES / NO  Torres Strait Islander YES / NO  Aboriginal & Torres Strait Islander YES / NO

**Country of birth** _____ **if not here, what year did you arrive in Australia:** _____

**Address:** _____

**Postal address** (if different)**:** _____

**Phone numbers:** (mobile) _____ (home) _____ (work) _____

**Email address:** _____

**Medicare card number:** _____ **IRN:** _____ **Expiry:** _____

**Entitlement Card:** NONE / PENSION CONCESSION / HEALTH CARE CARD / DVA / COMMONWEALTH SENIORS

**Card number:** _____ **Expiry:** _____

**Employed:** YES / NO **Occupation:** _____

**In case of emergency, please contact:** **Name:** _____

**Relationship:** _____ **Phone:** _____

PLEASE TURN OVER

**Next of Kin (if separate from emergency contact): _____**

**Relationship: _____ Phone: _____**

**Allergies:**

_____

**Smoking status:** SMOKER / EX-SMOKER / NEVER SMOKED **Cigarettes per day: _____**

**Year commenced: _____ Year quit** (if necessary)**: _____**

**How did you hear about us:**

◯ Internet search

◯ Word of mouth

◯ Facebook

◯ Instagram

◯ Outdoor signage

◯ Other: _____

If the patient is UNDER 18 years of age, please complete this extra section:

**Parent/Guardian name: _____**

**Is the parent/guardian a current patient:** YES / NO

If no, please supply the following information:

**Date of birth: _____ Mobile Number: _____**

**Address: _____**

**Medicare Number: _____ IRN: _____ Expiry: _____**

As part of a Quality Improvement Initiative by the Federal Government this clinic participates in de-identified data collection. If you would like to know how we do this, and have any questions around the privacy of the information collected, please ask at receptions and we will be pleased to talk to you about it.

Please tick this circle if you do not want your de-identified data included in our data collection. ◯

**Signed: _____**

**Name: _____ Date: _____**