CC MEDICAL New Patient Form

Welcome to Coleraine Casterton Medical – Please complete the following health questionnaire.

Title: ……. Surname: …… Given Names: ……

Address: ……

Telephone: *Home*…… *Work*…… *Mobile*……

Email: …… Occupation: ……

Date of birth: ……/……/…….. ☐ Male ☐ Female Country of birth: ……

Are you of Aboriginal or Torres Strait Islander origin? ☐ Yes ☐ No

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

Medicare Number…… Ref No ……. Expiry Date ……/……

Pension/Health Care Card: …… Card Type: ☐ Gold ☐ White

Veterans Affairs Card Number: …… Ref No ……. Expiry Date ……/……

Next of kin/emergency contact: …… Phone: ……

Relationship: ……

Medications list (include over the counter medication): ……

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Allergies: ☐ Yes ☐ No Please list ……

Do you smoke? ☐ Yes ☐ No ☐ Ex-smoker (if yes how many per day)……

Do you drink alcohol: ☐ Yes ☐ Never ☐ Not currently (if yes how many per week) ……

CC Medical uses SMS reminders & recalls – Please tick your preferences

☐ Yes SMS Reminders & Recalls ☐ No SMS Reminders & Recalls

I …… give consent for the collection and disclosure of information to relevant professionals as necessary for the management of my health. This information is in a computer database and all reasonable steps to protect privacy and to maintain confidentiality are taken, including secure hardware, passwords and staff confidentiality assurances.

I agree to pay all costs incurred during my visit to CC Medical. I acknowledge that, should my account extend beyond the CC Medical trading terms, then I will be responsible for all charges, fees, disbursements, legal costs and debt collection agency charges and commissions necessarily incurred in the collection of the overdue account.
I understand that payment of my account is my responsibility if my claim is rejected under the Work Cover Act or TAC (where applicable)
I understand that if payment is not received for services within 60 days then CC Medical may cease providing further Medical Services unless they are considered Life Threatening.

I acknowledge I have received a copy or been given the Privacy and Confidentially agreement to view at time of completing this form.

Patient Signature …… **Date** ……/……./……..