Livingstone Street Clinic

NEW PATIENT REGISTRATION FORM

(Please ensure that you complete all sections of this form and hand back to receptionist ASAP)

Title: _____ **Given Name**:_____ **Surname**:_____

Birth Sex: Male / Female / Other ……

Gender Identity: Male / Female / Other ……

Date of Birth: / /

Address: _____

_____

Phone No: _____

Mobile No: _____

Email: _____

Agree to receiving SMS: Yes / No

Ethnicity: _____

Country of Birth:

Medicare No: _____

Patient Individual No: ☐

Expiry Date: /

Health Care Card No: _____

Expiry Date: /

Pensioner Concession Card No: _____

Expiry Date: /

Veteran Affairs No: _____

Occupation: _____

Next of Kin: _____

Relationship of Next of Kin: _____

Next of Kin Phone No: _____

Emergency Contact Phone No: _____

Emergency Contact Name (if different from next of kin):

Do you identify as:

☐ Aboriginal ☐ Torres Strait Islander

☐ Aboriginal & Torres Strait Islander

For children under 18

Parent/Guardian Name:

_____

Date of Birth of Parent/Guardian / /

Address:

_____

_____

	Medicare No: _____ Patient Individual No: ☐ Expiry Date: /

Payment is required at time of consultation

We accept Cash, Cheque, Eftpos & Credit Cards. ***Amex and Diners not accepted***

PATIENT CONSENT FORM

Livingstone Street Clinic requires your consent to collect personal information about you. Please read this consent form carefully, tick the applicable boxes, and sign where indicated below.

The practice is committed to protecting the confidentiality of your personal information and health records. In submitting this form, you:

1. Acknowledge that we, and the service providers at Livingstone Street Clinic, will collect your personal and health information to enable the practice to provide you with the clinic's health services and any related communications (for example, to manage your appointment bookings); and
2. Consent to our handling of your personal information in accordance with our Privacy Policy which can be accessed on our website, or by asking us for a copy.

Do you agree to the terms?

I understand that by signing below, that the Practice is authorized on my behalf to use my personal health information, and I am free to withdraw my consent at any time by verbal or written notification.

Name of Patient_____

Signature of Patient_____

Print name and signature of Parent / Guardian (if patient under 18) _____

Date _____