BEACH STREET FAMILY PRACTICE

Please hand the completed form to the reception desk.

Title (please tick) – Mr ☐ Master ☐ Mrs ☐ Ms ☐ Miss ☐

Surname:_____

Given Name(s):_____

Date of Birth: ☐☐/☐☐/☐☐ **Marital Status**:_____

Address:_____

Suburb:_____ **Postcode**:_____

Phone:_____ **Mobile**:_____

Occupation:_____ **Work Ph**:_____

Medicare No: ☐☐☐☐☐☐☐☐☐☐ Patient No:☐ Expiry: ☐☐/☐☐☐☐

HCC/Pension Card: ☐☐☐☐☐☐☐☐☐☐ Expiry: ☐☐/☐☐/☐☐

DVA Gold Card: ☐☐☐☐☐☐☐☐ Expiry: ☐☐/☐☐☐☐

Consent for Contact:

- Permission to leave a message on your home phone: YES ☐ NO ☐
- Our Practice will send out letters for routine health reminders, are you happy for this to happen? ☐ Yes ☐ No

Private Health Fund: YES ☐ Name:_____

NO ☐

Are you: Non Indigenous ☐ Aboriginal ☐ Torres Strait Islander ☐ Sikh/Punjabi

Next of Kin-

Name:_____ Relationship:_____

Address:_____

Phone:_____ Mobile:_____

If on holiday, name of place you are staying: _____

The practice privacy policies are available on our website or ask out staff to print a copy