MARINERS MEDICAL

New Patient Details Form

Please assist us by completing the following information:

Surname		**Select** ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master	
First Name	**(Known as)**		**D.O.B.**
Street Address		**Suburb**	**Post Code**
Phone (H)	**Work**	**Mobile**	
Email Address			

Medicare Number * Patient Ref No. (Next to your name on the card)											*	Expiry Date
DVA Number										Expiry Date		
Pension Number											Expiry Date	
Health Care Card Number											Expiry Date	
Commonwealth Seniors Card											Expiry Date	

What is your Ethnicity (Country of Origin)?		
Are you of Torres Strait Islander Origin?	Yes ☐	No ☐
Are you of Aboriginal Origin?	Yes ☐	No ☐

Next of Kin	First Name	Surname	Relationship	Phone
Emergency Contact	First Name	Surname	Relationship	Phone
Do you have an allergy?	Yes ☐ No ☐ If yes, please provide details			

Would you like to receive SMS reminders for appointments and check-ups?	Yes ☐	No ☐
Would you like to be involved in recalls for preventative health?	Yes ☐	No ☐
Would you like to receive information regarding new services promoting preventative healthcare?	Yes ☐	No ☐
I consent to share my health information with other health professionals	Yes ☐	No ☐

How did you hear about us?	Yellow Pages ☐	Social media ☐	Web/Internet ☐	Word of Mouth ☐
	Flyer ☐	Advertising ☐ **Please advise which one**		

Privacy

All patient information is considered private and confidential and is only accessible to authorised staff members.
Due to the Privacy Act we need to know if at any time someone else may be collecting personal information for yourself ie; picking up prescriptions or referrals. If this is something you may need to do, please ask reception for a form to complete so that we have this information readily available when needed.

Signed	**Date**
For office use only: [ ] Driver's Licence/Proof of ID, scanned to patient file	