Integrated Specialist
Medical Care

New Patient Information Form

*** FIRST NAME**		*(Please Circle)* *** MS *MRS * MR *DR**
*** SURNAME**	**KNOWN AS**	
*** DOB:**	**EMAIL**	
*** HOME ADDRESS**		
*** SUBURB**		**POSTCODE**
*** POSTAL ADDRESS**	**SUBURB**	**POSTCODE**
*** HOME PH:**	**MOBILE**	**WORK PH**
*** NEXT OF KIN NAME:**	**CONTACT NO.**	**RELATION**

*****MEDICARE/HEALTHFUND/DVA DETAILS***

*** MEDICARE NO.**	**REF NO.**	**EXPIRY**
***DVA Gold / White** *(Please Circle)*		**EXPIRY**
*** PENSION CARD**	**REF NO.**	**EXPIRY**
*** HEALTH FUND**	**MEMBERSHIP NO.**	

*****REFERRING DOCTOR DETAILS:***

***DOCTORS NAME & ADDRESS:**
******GP IF DIFFERENT:**

DO YOU CONSENT TO HAVING YOUR HEALTH /APPOINTMENT REMINDERS SENT TO YOU BY SMS? ☐ Yes ☐ No

How did you initially hear about us?

- Sydney Morning Herald Advertisement
- Website
- GP recommendation
- Relative/Friend

We require your consent to collect personal and health information about you. Integrated Specialist Medical Care safeguards its confidentiality and privacy in accordance with the Australian Privacy Principals. We require you to provide us with your personal details and full medical history so that we may properly assess, diagnose and treat you and be proactive in your health care needs. This means we will use your information you provide in the following ways.

- Billing and administrative purposes including compliance with Medicare Australia
- Disclosure to others involved in your health care, including treating doctors & specialists outside this medical practice.

This can occur through referral to other doctors, referral for medical tests and in the reports and results returned to us following these referrals.

- To contact you for the purpose of Recalls and Reminders

Patients Signature _____ **Date**: _____