Geriatrician New Patient Form

Geriatric Care AUSTRALIA

PERSONAL DETAILS

First Name: ______________________ Surname: ______________________

Middle: ______________________ Preferred Name: ______________________

Date of Birth: ______________________ Gender: Male ◯ Female ◯ Other ◯

ATSI: ◯ Aboriginal or ◯ Torres Strait Islander Ethnicity: ______________________

CONTACT DETAILS

Home phone: ______________________ Mobile phone: ______________________

Street Address: ______________________

Suburb: ______________ State: __________ Postcode: __________

Email address: ______________________

Emergency Contact Details

Name: ______________________ Tel: ______________________

Relationship: ______________________

Next of Kin (if different to above)

Name: ______________________ Tel: ______________________

Relationship: ______________________

MEDICARE / DVA DETAILS

Medicare Card No. ______________________ Reference No. __________ Expiry: __________

Department of Veterans' Affairs card: ◯ DVA

Card No.	Expiry (mm/yy)	DVA Card Colour

Geriatric Care AUSTRALIA

CONCESSION CARD DETAILS

Aged pension card or healthcare card: ◯ HCC ◯ Pension

Card No. ______________________

Expiry (mm/yy) __________

SIGNATURE

Geriatric Care Australia collects information for the primary purpose of providing quality healthcare. We ask for personal details and a full medical history so that we may properly assess, diagnose and treat illnesses and be pro-active in healthcare delivery. We will also collect, hold, use and disclose the information you provide in accordance with the Privacy Act 1988 and Australian Privacy Principles (March 2014).

☐ I consent to Geriatric Care Australia requesting copies of my medical records from other providers and to receiving emails and SMS appointment reminders with the contact information provided.

☐ I agree to the assignment of the Medicare benefits directly to the doctor (for bulk-billing appointments), have read the Geriatric Care Australia Privacy Policy and consent to the use of my information as described (geriatriccareaustralia.com.au/privacy-policy)

Signature: ______________________________ Date D D M M Y Y

☐ I am completing this form on behalf of the patient (e.g. as next of kin, legal guardian, or authorised carer), I confirm I have the authority to do so, and the patient has consented where appropriate.

Email a completed New Patient Form and GP referral to: admin@geriatriccareaustralia.com.au