NEW PATIENT FORM

Surname:	
Given names:	
Mr,Mrs,Miss,Ms,Dr etc:	
Date of birth:	
Home phone number:	
Work phone number:	
Address:	
General practitioner: **(address & telephone number):**	
Health fund:	
Health Fund Membership No:	
Occupation:	
Referring doctor: **(address & telephone number)**	
Medicare No:	……….…. …………….. **Patient No on Card** …….. **Expiry Date**
Pension No.:	
Veterans' Affairs No:	
Medications You Are Currently Taking:	
Medications/Substances to Which You Are Allergic:	

I provide my consent for Dr O'Neill to collect, use and disclose my personal information as reasonably required for medical purposes. I understand that I am entitled to access my own health records. I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

Signed ……………………………………… **Date** …………………………………

Witnessed …………………………………