19 Norton Street Wangaratta Vic
Phone: 03 5723 5400
Web: northeastfamilymedicine.com.au
Email: admin@northeastfamilymedicine.com.au
ABN: 57 485 501 532

New Patient Information

Title: Mr / Mst / Miss / Ms / Mrs / Dr / Other:.....

Given Name(s): .....

Preferred Name: (if not as above).....

Last name:.....

Date of Birth: ...../...../..... Sex: Male ☐ Female ☐ Other ☐ .....

Country of Birth: Australia / Other: .....

Do you identify as Aboriginal or Torres Strait Islander?: Yes ☐ No ☐
If yes (please circle): Aboriginal / Torres Strait Islander / Aboriginal and Torres Strait Islander

Address:.....

Suburb:.....

State: ..... Post code:.....

Postal Address (if different to above): .....

Suburb:..... Post Code:.....

Mobile:..... Home:.....

Work:..... Other:.....

Email:.....

☐ Please tick this box if you do **NOT** give consent for North East Family Medicine to contact you about appointment reminders and health preventative strategies by phone or email.

Next of Kin:.....

Phone No:..... Relationship:.....

Emergency Contact: (if not as above) .....

Phone No:..... Relationship:.....

north east family medicine

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Medicare Card Number: ……

Reference Number:…… Expiry: ……/……..

Health Care/Pension Card:……

Expiry:……/……

DVA Card Number :…… Type: Gold / White

Private Health Insurance: Yes ☐ No ☐

Health Fund: ……

Card Number:……

Expiry:……/……

Previous Doctor/Medical Clinic:

Name/Clinic Name:……

Address:……

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I acknowledge as a new patient, that the account is to be settled at the times of consultation. I understand this North East Family Medicine is not a bulk-billing clinic.

Signature:…… **Date**: ……/……/……

How did you hear about us?

☐ Word of mouth ☐ Radio
☐ Chronicle ☐ Facebook
☐ Google ☐ Other:……