Lifeline
MEDICAL CENTRE

This clinic does NOT prescribe opioids, benzos or any other drugs of addiction to new patients.

PLEASE WRITE CLEARLY

New Patient Registration Form

We are committed to providing our patients with the best care. To do this, it is essential that your health record is kept up to date and accurate. Please assist us by completing the following pages:

=this information is completely voluntary and may help individualise and enhance your care

Any information is strictly private and confidential

Title:	Mr	Mrs	Ms	Miss	Master	Other:

Surname:

First Name:

Middle Name:

Preferred Name:

Sex:

Date of Birth:

Address:

Suburb: Postcode:

Mailing Address(if other than above)

Street address :

Suburb: Postcode:

Home Phone: Mobile Phone:

Work:

Email:

Occupation:

Medicare Number: Ref No: (number next to your name)

Medicare Card Expiry Date:

DVA Gold / White Expiry Date:

Pension/HCC Number: Expiry Date:

Private Health Insurance: Name of Company:

In which country you were born (Ethnicity)

Do you want SMS reminder please tick Yes ○ No ○

Do you identify as any of the following?

- ○ Yes - Aboriginal
- ○ Yes - Torres Strait Islander
- ○ No- Do not identify as an Aboriginal or Torres Strait Islander
- ◉ None

Do you require a translator?	No	Yes	Language?

Next of Kin (REQUIRED)

Name:

Address:

Contact Number: Relationship to Patient:

EMERGENCY CONTACT (if other than next of Kin)

Name:

Address:

Relationship to you:

Declaration:

I Date of Birth

- Confirm that the above details are true and correct. I acknowledge that I have read and understand the Policies and Procedures outlined on the Practice Information Sheet. I understand this is a private practice and full payment is expected on the day of consultation and that late fees may be billed if I do not pay on the day. I understand that reception can assist with any queries I might have with the Policies and Procedures outlined in the Practice Information Sheet.
- Consent to receive the SMS messages which can include accounts, appointment reminders, clinic reminder messages (please note you can revoke your permission at any time).
- Consent of sharing my information that has been collected to other providers (such as pathology, physiotherapists, other GPs, Specialists and Medicare for billing purposes etc.) in order to provide appropriate care, support and services according to my needs.

Please Note: Your consent to share information is valid indefinitely or until otherwise altered/revoked. We also must comply with any legislative or regulatory requirements and notifiable diseases also please note it is your responsibility to keep all personal information up to date and follow up on all test results in person.

Parents please sign this form on behalf of your children under the age of 16.

Signature: Date:

Updated on 20/06/2022