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New Patient Form

Adelaide City General Practice

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other (please specify)			
First Name:		Last Name:	
Preferred Name:		Date of Birth:	
Contact Details:			Male / Female
Street Address:			
Suburb:	State:	Postcode:	
Postal Address (if different from above):			
Suburb:	State:	Postcode	
In providing us with the telephone numbers below you are agreeing to the practice staff leaving messages identifying the surgery as the caller.			
Home:	Work:	Mobile:	
I consent to being contacted by SMS for reminders, recalls, results and other messages? **Yes / No**			

Other Information:

Marital Status:	Occupation:
Country of Birth:	
Do you need an interpreter? **Yes / No**	Language:
To assist with health initiatives - are you an Aboriginal or Torres Strait Islander? ☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander	
Please state other cultural background:	

Do you have any of the following cards?
☐ Medicare ☐ Health Care Card ☐ Pension Card ☐ Veterans Affairs
If you are an **OVERSEAS STUDENT** Please complete the following line:
OSHC Insurance Company: Policy No:

Next of Kin	Name:		
Relationship:		Phone:	Male / Female
Emergency Contact: (if not Next of Kin)	Name:		
Relationship:		Phone:	Male / Female

By signing this form I acknowledge that:

- Fees charged by Adelaide City General Practice (ACGP) relate only to services provided by ACGP General Practitioners and Nurses and that I am responsible for the payment of fees for other services (for example: pathology, radiology/imaging, specialists, allied health, pharmaceuticals, ambulance etc).
- I have been provided with a copy of the practice information brochure, including the privacy statement.
- I will be personally responsible for the payment of non-attendance fees should I fail to attend an appointment or to give four hours' notice when cancelling an appointment.

Signature:	Date: