PATIENT PERSONAL DETAILS

ARGYLE MEDICAL
GENERAL PRACTICE

SURNAME:

GIVEN NAMES:

PREFERRED NAME: Male ☐ Female ☐

EMAIL:

DATE OF BIRTH: ETHNICITY:

ABORIGINAL: Yes ☐ No ☐ TORRES STRAIT ISLANDER: Yes ☐ No ☐

ADDRESS:

SUBURB: POSTCODE:

PHONE (HOME): PHONE (WORK/MOBILE):

DO YOU CONSENT TO SMS REMINDERS & EMAIL CONTACT? Yes ☐ No ☐

OCCUPATION:

PREVIOUS/USUAL DOCTOR:

MEDICARE NUMBER: __ __ __ __ __ __ __ __ __ __ __ REF: EXPIRY: _____ / _____

HEALTH CARE CARD NO.: EXPIRY: _____ / _____

DVA CARD NO.: EXPIRY: _____ / _____

EMERGENCY CONTACT PERSON:

RELATIONSHIP:

ADDRESS:

SUBURB: POSTCODE:

PHONE (HOME): PHONE (WORK/MOBILE):

HOW DID YOU CHOOSE THIS PRACTICE? (PLEASE TICK)

☐ REFERRAL ☐ TV ☐ RADIO ☐ MAIL ☐ YELLOW PAGES ☐ INTERNET ☐ OTHER: (PLEASE SPECIFY)

Ask our reception staff about online booking. (You will receive a confirmation and information via email)

☐ I confirm that all the information supplied on this form is correct. I accept the pricing policy of the practice and will take responsibility for my fees. I understand that any consumables used may incur additional charges to the consultation fee. I also understand that some services, such as pathology and radiology, are provided by third parties, and that such services are subject to the pricing policy of the external provider.

SIGNATURE

DATE