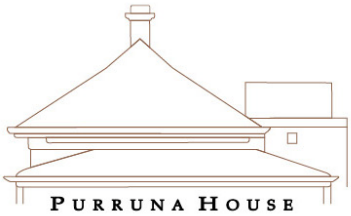

Adelaide Physicians & Surgeons

New Patient Form

Welcome to **Adelaide Physicians & Surgeons**

We ensure that your details disclosed below will be kept confidential whilst we provide quality healthcare to each patient.

Mr / Mrs / Ms / Miss / Dr _____ _____ (please circle) (Given Names) (Surname)	
Date Of Birth :	
Address:	
Suburb:	Post Code:
Home Phone:	Mobile:
Email Address:	
Medicare/DVA No:	Ref No:
Pension/Concession No:	
Private Healthcare Fund Name:	Member No:
Next of Kin:	Phone:
Referring Doctor: Location:	**Usual GP Name**: Location:
Work Cover/Third Party/MVA Details:	
Claim No:	Employer Name:
Date of claim/injury:	Name of the Insurer:
Allergies:	

Adelaide Physicians & Surgeons will collect information for the primary purpose of providing quality health care. We require details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare needs. We may disclose this information to other healthcare providers directly or indirectly involved in your personal healthcare or medical treatment. As part of our reminder services, we may SMS your next appointment time.

All fees incurred per appointment must be settled on the day of consultation. Most healthcare services provided by this practice are covered in part, by Medicare. We ask that payment of your account is settled at the completion of your consultation. Eftpos facilities are available and we are happy to send your paid account to Medicare for reimbursement.

I have read and understand the above statement. I am aware of my obligatons and also the obligations of the practice.

Signature: _____

Name: _____ Date: _____