# NEW PATIENT FORM

**Patient Details**

Title: MR First Name: KASEY Middle Initial: R

Surname: JONES Preferred Name: KASEY

DOB: 16/12/13 Gender: MALE Gender Identity: MALE

Home Address: 40 TOLEDO CIRCUIT PORT KENNEDY

Postal Address: _____

Email: MIRANDA.MORRISON89@OUTLOOK.COM

Home Ph: _____ Mobile: 0431052448

Work Ph: _____

Marital status: _____ Occupation: _____

Ethnicity: _____ Country of Birth: AUSTRALIA

Is English your first language? (Yes) / No Do you require an interpreter? Yes / (No)

If yes, specify language: _____

Do you identify as: Aboriginal / Torres Strait Islander / Both

**Billing Information**

Medicare No.: 6245 82744 5 Ref No.: 4 Exp: 06/2026

Concession CRN: _____ Type: _____ Exp: _____

DVA No.: _____ Colour: _____ Exp: _____

Conditions (White card only): _____

**Next of Kin Details**

First Name: MIRANDA Surname: MORRISON

Phone No.: 0431052448 Relationship: MOTHER

Address: 40 TOLEDO CIRCUIT PORT KENNEDY

**Emergency Contact Details (if different to NOK)**

First Name: RAYMOND Surname: MORRISON

Phone No.: 0459570046 Relationship: FATHER

**Medical History**

Allergies/ Intolerances: _____

Reactions: _____

Medical Conditions & Diseases: ADHD

_____

Current Medications & Doses: DEXAMPHETAMINE 2.5MG MORNING

5MG LUNCH

Are you a current smoker?: Yes / (No) If yes, how many per day?: _____

Are you a previous smoker?: Yes / (No) If yes, what year did you quit?: _____

Do you consume alcohol?: Yes / (No)

How many drinks per day?: _____ How many drinks per week?: _____

Do you use illegal substances/ drugs?: Yes / (No)

If yes, please list type and frequency: _____

**Privacy & Consent**

By signing below, you (as patient/ guardian) are consenting that on obtaining your personal information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/ recall notices for treatment and preventative health care including phone, post, email and SMS.
- For accounting procedures and the collection of professional fees
- The diagnosis and treatment of my condition, including the communication of relevant information to practice staff, specialists and other health care providers to ensure quality care is provided
- For legal related disclosures required by the court of law, mandatory reporting of neglect or abuse, and for disease notification as required by law
- For reporting of records and results to the Australian Immunisation Register and the National Cancer Screening Register
- For use when seeking treatment by other doctors in this practice
- For obtaining medical records, previous clinic reports, results and management plans from other medical practitioners, institutions, laboratories and other third-party organisations.
- To inform the next of kin identified in my patient information of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent
- To contact your emergency contact in the case of an emergency relating to your health care, or if the practice has been unable to contact you directly
- To consent for messages to be left on your telephone answering service or message bank regarding matters of your health.

By signing below, you (as patient/ guardian) also acknowledge the following:

- St James Medical Centre is a mixed billing practice and some private fee's apply. You are responsible for payment in full at the conclusion of your appointment.
- You understand that St James Medical Centre complies with the Australian Privacy Act (1988).

Patient/ Guardian Signature: _____ Date: 21/08/22

Guardian Name (if patient is under 16 years): MIRANDA MORRISON

**How did you find out about us?** _____