

**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 827445 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: _____

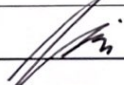
Privacy & Consent

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? _____