Woollahra
Family Medical Practice

NEW PATIENT REGISTRATION FORM

Welcome to Woollahra Family Medical Practice. Please fill in all the information below:

TITLE: (please circle) MR MASTER MRS MS MISS DR OTHER: _____

FIRST NAME: _____ LAST NAME: _____

GENDER IDENTITY (circle): MALE FEMALE NON-BINARY TRANSGENDER OTHER

DATE OF BIRTH: _____ COUNTRY OF BIRTH: _____

NATIONALITY/ETHNICITY: _____

ADDRESS_____

SUBURB: _____ STATE: _____ POSTCODE: _____

HOME PHONE: _____ MOBILE PHONE: _____

EMAIL ADDRESS: _____

MEDICARE NUMBER: _____ IRN: _____ Exp: _____

PENSION/HEALTH CARD NUMBER: _____ Exp: _____

DO YOU CONSENT TO APP NOTIFICATIONS, SMS RECALLS AND REMINDERS FROM US:

□ YES □ NO

NEXT OF KIN NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

EMERGENCY CONTACT: NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

YOUR SIGNATURE: _____ DATE: _____

Please be aware that by signing this form, you consent:

1. For our GPs and practice staff to access and use your personal information so they can provide you with the best possible healthcare. For more information, please read our privacy policy.
2. That full payment is required at the time of Consultation – See our website and the practice area for schedule of fees
3. Woollahra Family Medical Practice uses MyPractice App for notifications, recalls, reminders, escripts and ereferrals. Please let us know if you do not intend to download the app. Please see the MyPractice privacy policy for more information.
4. We communicate to our patients with regards to non-clinical matters via email. Please be aware that the information could be intercepted or read by someone other than the intended recipient. Emails are only attended during opening business hours.