

# **NEW PATIENT FORM**



Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

Gender: \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

First Name \_\_\_\_\_ Surname \_\_\_\_\_

Country of Birth \_\_\_\_\_ Ethnicity / Nationality \_\_\_\_\_

Residential Address: \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

Postal Address: \_\_\_\_\_ Postcode \_\_\_\_\_

Phone \_\_\_\_\_ Mobile \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status: Single / Married / Widowed / Divorced / De Facto / Separated

## **PATIENT'S EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

Contact Phone Number \_\_\_\_\_

## **BILLING**

Do you have private health cover? Yes / No Name of Insurer \_\_\_\_\_

Medicare Card # \_\_\_\_\_ / \_\_\_\_ (Ref on card) Expiry Date \_\_\_\_ / \_\_\_\_

HCC / Pension Card # (Circle One) \_\_\_\_\_ Expiry Date \_\_\_\_ / \_\_\_\_

DVA Card No. \_\_\_\_\_ Gold / White (Circle One)

## **FEES**

Noosativa is a Privately Billed Medical Practice. Bulk billing is at the sole discretion of the doctor and does not apply to Cannabis Prescription Medicine Applications. For privately billed consultations, fees are payable at the time of consultation. Medicare rebates, where applicable will be processed automatically through Medicare and paid into the bank account patients have registered with Medicare.

## **CONSENT**

I consent to the disclosure of my personal health information by Noosativa onto other health providers directly involved in my personal health care or medical treatment. I understand my information will not be disclosed to any third party, without prior written consent by patient.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Noosativa**

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