M O S S S T R E E T M E D I C A L P R A C T I C E

1 MOSS STREET NOWRA. NSW. 2541.

NEW PATIENT INFORMATION/CONSENT:

Title: Name:

Date of Birth: / / Preferred Name:

Street Address:

Suburb : Postcode:

Postal Address (If different from above):

Home Phone: Mobile:

Do you consent to SMS reminder for extended and nurse appointments? YES ☐ NO ☐

Email: Occupation:

Medicare Number: _ _ _ _ _ _ _ _ _ _ Position on card : Expiry:

☐Pensioner/ ☐Concession/ ☐Health Care Card : Expiry:

DVA card: Type: GOLD ☐ WHITE ☐

Do you identify as (***please tick***): ☐Aboriginal ☐Torres Strait Islander ☐non aboriginal/Torres Strait islander

Emergency Contact:

Phone: Relationship:

Next of Kin: (if different from above)

Phone: Relationship:

I (below patient) provide consent for GP's and staff from Moss Street Medical Practice to access my personal information for medical/clinical purposes in adherence to our privacy policy. If you require further information please read our privacy policy displayed in the waiting room or ask reception staff for assistance.

Patient Name:

Patient Signature: Date: