1/55 Murdoch Drive Greenfields
t: 08 9535 3244
f: 08 9534 7150
w: www.dynamicdoctors.com.au
e: admin@dynamicdoctors.com.au

NEW PATIENT REGISTRATION FORM

The Doctors and Staff are committed to Patient Care, driven by Values Expertise and Experience.
Please complete the following form. **All information will be treated confidentially.**

Section A: Personal details

Title Dr Mr Mrs Ms Miss

Surname: ____

First Name: ______________________ Known as: ______________

Date of Birth: ______________________ Gender: Male Female

Marital Status: Married De facto Single Widow Divorced

Australia is a multi-cultural society. Do you identify as being a part of a particular cultural group? (e.g. Maori, Baha'I, Jehovah's Witness etc.) Please also indicate if you speak a language other than English.

____

Are you of an Aboriginal or Torres Strait Islander origin: Aboriginal Torres Strait Islander No

Home Address: ____

Postal Address: ____

Home Phone: ________________ Mobile Number: ____________________

Work Phone: ________________ Email Address: ____________________

Preferred Contact method: Home Mobile Email Consent to SMS Reminder:

Occupation: ____

Person responsible for paying account: ______________________________

Emergency Contact (Local Person):

Name: ______________________ Relationship to Patient: __________

Home Phone: ________________ Mobile Number: ____________________

Next of Kin

Name: ______________________ Relationship to Patient: ____________________

Home Phone: ________________ Mobile Number: ____________________

Guardian or Parent (must be completed if patient is under the age of 18)

Name: ______________________ Relationship to patient: ____________________

Guardian\ Parent DOB: __________ Gender: Male or Female

Home Address: ____

Home Phone: ______________________ Mobile Number: ____________________

Dr Keith Williams. Provider: 2983805F
Dr Mirna Williams. Provider: 2991703K
Dr Bryan Rostin. Provider: 233746HW
Dr Johannes Brink. Provider: 4004776F
Dr Hendrik van Rooyen. Provider: 2751395B
Dr Vivien Dempsey. Provider: 2904495L

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Section B: Medicare, Concession and DVA

Medicare Card No: ________________________ Reference No: _____ Expiry Date: ___/______

Health Care / Pension Card: __________________________ Expiry Date: _____/___/______

DVA: ___________________________________ Expiry Date: ___/______ Gold White

Section C: Allergies (Including Medication allergies)

Type of Allergies:	**Reaction:**
__________________________________	______________________________
__________________________________	______________________________
__________________________________	______________________________

Section C: Reminder and Results

Reminders: This practice takes a preventive approach to your health. You may receive a reminder letter in your mail box or be reminded at your next consult about ongoing follow-up preventive care.

Consent: Yes No

Results: This practice will contact you when required with regards to Results. We must obtain your consent for messages to be left on your telephone answering machine or mobile message bank regarding matters involving you Results.

Consent: Yes No

Section D: Privacy Policy

I acknowledge that Dynamic Doctors is a Mixed Billing Practice and I may be charged a private consult fee. Bulk Billing is available, at the discretion of the treating doctor, to pension and healthcare card holders as well as children under the age of 16 years on week days. If a private consultation fee is charged, payment in full is require at the end of your consultation.

Accounts can be paid for by: Cash EFTPOS Visa or MasterCard

Dynamic Doctors Group is committed to maintaining the confidentiality of your personal information. It is policy of the Practice to maintain the security of personal health information at all times and to ensure that this information is only available to Health Practitioners consulted within the practice and other Health Practitioners involved in the management of the patient. Information may be disclosed to other organisations where required by law or if necessary, contact details may be disclosed for debt recovery purposes.

Patient Signature/Guardian/Parent: ____________________________________ Date: ____________

Patient Name (Printed): ____ DOB: __________