BLUEWATER MEDICAL PRACTICE & ACUPUNCTURE PTY LTD

BMP

NEW PATIENT REGISTRATION FORM

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. If any of the following details change in the future, we ask that you advise us at your earliest convenience.

Title (please circle)	MR MRS MS MISS			
Surname				
First Names	**Date of Birth**:			
Street Address				
Suburb	**Postcode**			
Postal Address (if different to Street Address)	**Postcode**			
☐ (Please tick) I give consent to be contacted regarding my Health Care by : (Please Tick one or more of the following) All available options on my file ☐ SMS ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Work Phone ☐				
Home Phone		**Work Phone**		
Mobile Phone		**Email Address**		
Medicare Card Number		**No. On Card:**	**Expiry**	
DVA Gold // White			**Expiry**	
Health Care Card Number			**Expiry**	
Pension card			**Expiry**	
Private Health Cover	**Name of Fund:**			
Emergency/Next of kin (Must be completed)	**Name:**	**Relationship:**	**Telephone:**	

1. Do you identify as someone from a culturally and/or linguistic diverse background? ☐ Yes ☐ No (if No go to 3)

2. Country of Birth _____ NATIONALITY _____

3. Do you require an Interpreter Service: ☐ **YES** ☐ **NO** If so, in which Language:_____

4. Do you identify as Aboriginal or Torres Strait Islander?

☐ No ☐ Yes-Aboriginal ☐ Yes-Torres Strait Islander ☐ Yes -Aboriginal & Torres Strait Islander

Signature: …… **Date:** ……

This Practice follows the guidelines of the amendments to the Private Policy Act 1988.
If you wish to see a detailed copy of the Privacy Policy Act 1988, please ask Reception. Please be assured that the details you are about to provide will not be passed on to any person or business outside this practice and all details will be securely disposed of.