SAPPHIRE
FAMILY MEDICAL PRACTICE

Patient Information Form / Update of Personal Details

Title:.....

Name: .....

Date of Birth: .....

Country of birth: .....

Street Address: .....

Suburb or City:..... Postcode:.....

Home Telephone Number:.....

Mobile Number: .....

Email Address: .....

If email address provided, would you like to receive our monthly email newsletters: ☐ Yes ☐ No

Medicare Number: ..... Medicare Line:.....

Medicare Expiry Date: .....

Emergency Contact Name:Emergency Contact Number: .....

Next of Kin Name:..... Next of Kin Contact No:.....

How did you hear about our practice?.....

Are you an Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

If NO what is your Ethnicity? .....

Please provide your Medicare Card and Driver's Licence to the reception staff.

I consent:

- To my information being used for administration and billing purposes
- To my information being shared with other doctors within the practice for patient care, teaching and quality improvements
- To make a follow-up appointment for results
- To receiving reminder letters which may be sent regarding my healthcare and management
- To providing my health information and I understand how it will be used by the Staff of Sapphire Family Medical Practice
- **That appointments cancelled with less than 24 hours notice will incur a full cancellation fee**
- To the fees of the practice and I am aware additional fees may apply
- To receive SMS reminders

Patient signature: ..... Date: .....