SAPPHIRE
FAMILY MEDICAL PRACTICE

Patient Information Form/ Update of Personal Details

Title: ……

First Name: ……. Last Name: ……...……

Birth Gender: ☐ Male ☐ Female ☐ Other (please describe) ……

Gender Identity: ☐ Male ☐ Female ☐ Other (please describe) ……..

Date of Birth: …….

Country of birth : ……

Street Address: ……..…….....

Suburb or City : ……..Postcode:…….

Home Telephone Number: ……

Mobile Number: ……

Email ……

I consent to SMS correspondence ☐ Yes ☐ No

Medicare Number: ……...……..Medicare Reference Number: …….

Medicare Expiry Date: …….

Emergency Contact Name: …….…… Relationship:…….. Number: …….

How did you hear about our practice? …….

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

What is your Nationality?……

Allergies ……...

Do you consent for your doctor to upload your health summary to your My Health Record? ☐ Yes ☐ No

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 improvement
- To make a follow up appointment for results
- For reminder letters which may be sent regarding my healthcare and management
- I am familiar with health information collection and use provided to me by Sapphire Family Medical Practice
- **Appointments cancelled with less than 24hrs notice will incur a full cancellation fee**
- **To pay the private fee associated with SFMP and full payment at the time of the appointment**
- **Payments made by credit card will incur a fee**
- I am aware that additional fees may apply for consumables

Patient signature…… Date:……..