Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Surname:___________________________________ **Given Names**: ________________________________ **Date of Birth**: / / **Sex**: Male ☐ Female ☐	 105 East Street Rockhampton Qld 4700 Telephone: 49 224 126 Facsimile: 49 227 536

Marital Status:	Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Defacto ☐
Ethnicity	Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Non ATSI ☐ Other______________________ Do you require a translator? Yes ☐ No ☐

Administration Details

Residential Address:		
Postal Address:		
Home Phone:	**Work Phone:**	**Mobile Phone:**
Medicare Number:	___________________________________ Reference No: ____ Expiry Date: ____ / ____	
Concession Details:	Yes ☐ No ☐ **Please Circle**: Health Care Card / Pension / Veteran Affairs Card No Number on Concession Card: _______________________________ Expiry: ___ /____ / ___	
Private Health Fund:	Fund:	Membership No:
Email Address:		
Occupation:		Employer:
<u>Allergies:</u>	Nil Known ☐ Yes ☐ Details:	
Next of Kin:	Name: Phone: Relationship:	
Emergency Contact:	Name: Phone: Relationship:	
Access to Medical Records Authorisation: **(Family member or partner to ring for results etc on your behalf)**	*I give permission for ______________________________________, DOB: ___ / ___ / ___, to obtain full access to my medical records. Ie. Ring for results or check on appointments etc.* This is required if you wish for someone else (eg. Family member, partner) to be able to ring for results etc. **This applies for all people aged 16 years and over**. ***<u>If this authorisation changes, it is the responsibility of you, the patient, to contact us and amend this authorisation.</u>***	
Consent:	**By signing this form I agree to the following:** • *I authorise the practice to obtain copies of any medical information about me from/send copies of any medical information about me to (delete whichever does not apply) other health professionals as required.* • *I understand that any information provided by me will be confidential.* • *I am aware that **City Heart Medical is not a BULK BILLING PRACTICE** and I agree to pay all fees charged by the practice.* • *I agree to pay all costs associated with the collection of overdue or unpaid accounts including a late payment fee.*	
Signature ✍ :		**Date**: ___ / ___ / ___