



WELCOME TO THE HEALTHHUB TAREE & HARRINGTON

New Patient Information Form



Mr/Mrs/Ms/Other.....Name:		Date of Birth:
Home Phone:	Work Phone:	Mobile: (SMS)
Address:		
Email address:		
*Please write your Medicare /HCC/Pension card No. below or give to the reception to add to your records		
Medicare No:.....Ref No:.... Expiry Date.....		
Health Care /Pension Card..... Expiry Date.....		
DETAILS OF YOUR NEXT OF KIN and EMERGENCY CONTACT		
Name:		Contact No:
Relationship:		

Place of Birth:
 Australia: Other _____

Are you a returning Medisense patient?
 Yes No

Do you identify as
 Aboriginal
 Torres Strait Islander
 Both Aboriginal & Torres Strait Islander
 None of the above

Past health e.g. mental health, any surgery

Date	Details

Covid Vaccinations:
 1st:.....
 2nd
 3rd

Do you have any allergies?

Medications: (including over the counter medications)

Do you consent to us leaving a message on your phone stating that we are from the medical practice?
 Yes No

By signing this document, you are stating you are aware we are a private paying practice and you are responsible for all payments issued by the practice for both in person and phone consultations. This excludes Vet Affairs & Aboriginal and Torres Strait Island patients.

Signature: _____ **Date:** ____/____/____
(If under the age of 16, parent or guardian should sign, stating relationship to patient)

All information disclosed in this form will be treated as confidential by the HealthHub Staff.