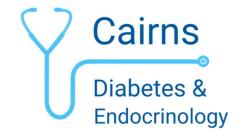
New Patient Information



Title:	Title: First Name:				Surname:				
Preferred Name	DOB:								
Residential Addr	ess:			I					
Postal Address:									
Email Address:		Occupation:							
Ph Home:			Ph Work:			Ph Mob:			
What is your pre	eferred metho	d of contact.	tick as many as appl	licable)					
🗌 Mobile			Home Phone	🗌 Email				□ Next of Kin	
Medicare Care Number:			Reference No: (dig	igit in front of name)				Expiry:	
Health Fund Nar	ne:			Health Fu	Health Fund Card Number:				
Do you hold any	of the followi	ng concessio	ons:						
DVA Go		D'	VA White	A White ADF Mem					
Card/Policy Num		Expiry:							
Do you identify a	s:								
Aborigi	nal		orres Strait Islander		Both			Neither	
Social history:									
Tobacco use	No	n Smoker	ker per	rper: Day / Week			Ceased smoking:		
Alcohol intake	Non Drinker units per: D			ay / Week / Month <i>(please circle)</i>					
Referral informat	ion:								
Referring Doctor	Clinic:	Clinic:							
General Practitioner:				Clinic:	Clinic:				
Next of Kin:									
Name:									
Relationship:				Phone Number:					
Emergency Conta	ct • (if differer	t from abov	e)	I					
Name:			c,						

 Relationship:
 Phone Number:



Consent to release medical information:

- □ I give my consent to **Cairns Diabetes & Endocrinology**, or their agents or advisors, to contact medical practitioners or other bodies I have consulted to obtain health and other information that may be pertinent to my care.
- □ Information can be transferred to and from medical practitioners and other bodies by channels such as email, fax and secure message systems.
- □ I authorise those medical practitioners or bodies to release such information, which may include sensitive information to **Cairns Diabetes & Endocrinology**, or their agents and advisors, as may be required.

Patient Details:

Patient name:	
Date of Birth:	
Signature:	
Date:	

Parent/ Guardian Details:

Parent/Guardian name:	
Signature:	
Date:	