**SUNSHINE COAST RENAL CLINIC – NEW PATIENT FORM**

**This information is private and confidential and is for use in your clinical file only**

**NEW PATIENT DETAILS -**  **Please print and give as much detail as possible to assist us to provide quality care.**

Full name: Mr Mrs Ms Miss Dr Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_/\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Business: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_contact at work yes/no

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ref no \_\_\_\_\_\_\_(next to name) Expiry \_\_\_\_\_\_\_\_\_\_\_

Vet Affairs No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ref no \_\_\_\_\_\_\_ (next to name)

Pension/Healthcare Card No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp\_\_\_\_\_\_\_\_\_\_\_

Private Health Fund. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fund Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Usual pathology provider:

QML 🞎 SULLIVAN & NICOLLAIDES 🞎 HEALTHSCOPE 🞎 COASTAL PATHOLOGY 🞎

Do you see any other specialists on a regular basis that you would like your correspondence to go to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your regular GP**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT TO USE PERSONAL INFORMATION**

This practice complies with the Privacy Act 1988, including the way we collect, store, use and disclose health information. This practise participates in medical research programmes and non identifying clinical information may be utilised for teaching and publication purposes. Personal information obtained from you in your consultation may be used to provide information to your referring and other medical practitioners and allied health professionals. I also give my permission for Sunshine Coast Renal to request my medical history from any public and private hospitals, general practitioners or specialist surgeries to assist in my medical treatment if required.

I HEREBY CONSENT TO MY PERSONAL INFORMATION BEING RELEASED AS AND WHEN REQUIRED.

PATIENTS SIGNATURE DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_