MANNING VALLEY MEDICAL PRACTICE

90 Albert Street, TAREE NSW 2430
PHONE: (02) 5591 8417 FAX: (02) 5591 8418

Dr Ruwaida AL-RUBAI
Dr Bharti PATEL
Dr Hema PHIRANGI

NEW PATIENT INFORMATION SHEET

Please fill out ALL of the form to ensure we can provide the best possible care available.

How did you hear about our practice? ______________________________________

Surname:	Title: Mr Mrs Dr Miss Ms
First Name:	**Known As:** Male Female
Single Married Widowed De Facto	
DOB:	
Residential Address:	
Mailing Address:	
E-mail Address:	
Phone No:	**Mobile:**
Medicare Card No:	Ref: Expiry:
Concession Card HCC/Pension/Seniors/DVA : No:	Expiry:

Do you **identify** as: Aboriginal Torres Strait Islander Both Neither
If **Yes** are you registered for the "Close the Gap" program? Yes No
COUNTRY OF BIRTH: **Please advise if an interpreter is required**

Occupation:	**Employer:**
If this visit is under Workers Compensation please complete this section:	
Address:	
Insurance Company:	Claim No:

Next of Kin:	Relationship:
Phone No:	
Emergency Contact:	Relationship:
Phone No:	

Do you have any known allergies? □ No □ Yes. Type: ________________________________

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PRIVACY STATEMENT

- We acknowledge our obligations to you under the Privacy Amendment (Private Sector) Act 2000.
- Personal information we collect from you will be used primarily to ensure that you receive optimal care, but may be used for other purposes such as communication with other Health Organisations, Allied Health Service Providers, Medical Practitioners, and Specialists and if we want to use the information for other purposes (such as research and auditing), we will ask for your consent.
- Our **"Personal Information, Privacy and Your Doctor"** brochure is available at reception and our staff are happy to answer any questions you may have concerning the Policy.

I,...hereby acknowledge receipt of and
Print Name

consent to the use of personal information as described in Manning Valley Medical Practice's Privacy statement.

Signature **Date**

THIRD PARTY AUTHORITY

I, _________________________, give permission for _________________________ to make enquiries on my behalf. I understand that by signing this form I give permission for the above named to communicate with the staff of Manning Valley Medical Practice on my behalf.

I understand that by signing this form I authorise _____________________ to be able to collect prescriptions/referrals and other documents Manning Valley Medical Practice.

FOR THIRD PARTY ATTENDANCE IN YOUR CONSULTATION

The staff at Manning Valley Medical Practice are required, by law, to ascertain whether a third party has been authorised to attend your appointment. For any ongoing third party attendees (eg spouse, parent), please complete below.

I, _________________________, give permission for _________________________ to attend my medical consultations at Manning Valley Medical Practice.
I acknowledge that I can withdraw my consent at any time and will advise practice staff or my doctor shall this occur.

Patient Signature: **Date:**

Comments: