KRS HEALTH
Kind Respectful Service

Quality Practice Accreditation

PATIENT NFORMATION FORM
NEW PATIENT /UPDATE INFORMATION

Date / /   Staff Initial __________

Title (please circle)	Mr Mstr Mrs Ms Miss
Gender	
Given Name	
Family Name	
Date Of Birth	
Street Address	
Suburb, State & postcode	
Contact number	
Email address	
Preferred method of contact	☐Email ☐ Mobile ☐ SMS ☐ Phone Call

Medicare Card No		Ref Exp
DVA (please circle)	Gold White	Expiry
Pension Card No		Expiry
Health Care Card No		Expiry

PLEASE NOTE: The Following is needed if we are unable to contact you personally.

Next of kin ☐**YES, I DO** want my NOK to have access to my results AND medical information	Full Name: Mobile: Relationship to you:
Emergency Contact ☐ **YES, I DO** want my emergency contact to have access to my results and medical information	Full Name Mobile: Relationship to you:
Cultural Identity (please Circle)	Aboriginal Torres Strait Islander Both Neither
Ethnicity	
Interpreter required	☐Yes ☐No Language
Patients Signature	

Acknowledgement of country
We Acknowledge aboriginal and Torres Strait Islander people as the traditional custodians of the land in which we meet.
We pay our respects to the elder's past, present and future

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