Bayside Family Medical & Musculoskeletal Practice
Patient Information Form

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate. Could you please assist by completing the following?

Title - please circle	Mr Mrs Ms Miss Dr Other _____				
Surname		**First Name**			
Date of Birth					
Street Address					
Postal Address					
Suburb and Post Code					
Home Phone	**Mobile Phone :**		**Work Phone:**		
Email (optional)					
Country of Birth					
Medicare Number		**Ref No**		**Expiry Date**	
DVA Gold / White (Please circle)				**Expiry Date**	
Pension Number				**Expiry Date**	
Health Care Card Number				**Expiry Date**	
Private Health Cover	Health Fund _____ **Hospital cover:** Yes ( ) No ( ) **Extras cover:** Yes ( ) No ( ) **Ambulance cover:** Yes ( ) No ( )				
Next of Kin	Name _____ Relationship _____ Contact phone _____Mobile_____				
Emergency Contact	Name _____ Relationship _____ Contact phone _____Mobile_____				
Occupation [if retired occupation retired from]					

Australia is a genuinely multicultural society. To tailor appropriate care for people from different nationalities and backgrounds, do you identify as from a culturally diverse and/or non- English speaking background?

If Yes, are you of or from?

☐ Aboriginal origin ☐ Torres Strait Islander Origin ☐ Both (ATSI) ☐ Neither

☐ Other cultural or ethnic background (please indicate)_____

Please present your Medicare card and any Concession cards to the front desk at every appointment.

Bayside issues appointment reminders / recalls via SMS

_____ _____

Patient Signature Date