New Patient Registration Form

Wheels of Wellness Mobile Clinic

Please tick ☐ Mr ☐ Master ☐ Miss ☐ Mrs ☐ Miss	**Surname**			
Given Names				
Date of Birth				
Street Address				
Suburb			**Post Code**	
Postal Address				
Suburb			**Post Code**	
Home Phone			**Work Phone**	
Mobile Phone				
Email Address Please ensure correct spelling & write clearly				
Occupation				
Medicare Number		**IRN**	**Expiry Date**	
DVA Gold / White			**Expiry Date**	
Pension Card or Health Care Card			**Expiry Date**	
Nationality				
Do you identify as	☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander			
Next of Kin	**Name**		**Relationship**	
	Phone number			
Emergency Contact	**Name**		**Relationship**	
	Phone number			

Currently sleeping

☐ Couch surfing ☐ Park/Bushland ☐ Hostel/transitional accommodation
☐ Car ☐ Squat ☐ Housed
☐ Streets ☐ Emergency /crisis accommodation ☐ Other:_____

Do you have a regular GP? ☐ Yes ☐ No

Name of GP	
Name of GP practice	
Address	
Phone number	

Date of last GP Visit:

Last ED Presentation_____ Reason for presentation_____

_____

How often have you visited ED? Or any other Emergency department in the past year?
☐ 1 visit ☐ 2-5 visits ☐ More than 6 visits

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Privacy

Your medical record is a confidential document. It is always the policy of this practice to maintain the security of personal health information and to ensure that this information is only available to authorised members of staff.

Please refer to our Privacy Policy located on our website wow.org.au

Data

Wheels of Wellness participate in Quality Improvement involving the sending of de-identification information for Health Data. Please inform reception/staff if you do not wish to participate.

Do you consent to the Doctors at Wheels of Wellness uploading and accessing your My Health Record?

☐ Yes ☐ No

Do you wish to receive SMS notifications from Wheels of Wellness?

Appointment reminders ☐ Yes ☐ No

Clinical Reminders ☐ Yes ☐ No

Clinical Communications (Results & Clinical Messages) ☐ Yes ☐ No

Health Awareness (Leaflets & Database) ☐ Yes ☐ No

Do you consent to the Staff at Wheels of Wellness sending Emails to you which may contain private/clinical information?

☐ **Yes** ☐ **No**

If you request to communicate with us via email, we remind you that this is not encrypted, and we do not send information via this means, without your consent.

Signature: _____ **Date:** _____