NEW PATIENT CONFIDENTIAL INFORMATION
(Please complete in BLOCK letters)

Surname: _____ First Name: _____

Preferred pronouns: She/Her He/Him They/Them Other: _____

Date of Birth: _____ Nationality: _____

Postal address: _____

_____ Post code: _____

Ph. (mobile): _____ Ph. (home): _____

Email : _____

Preferred method of contact: Home phone ☐ Mobile ☐ Post ☐ E-Mail ☐

Medicare Number: ☐☐☐☐☐☐☐☐☐☐

Number next to your name: ☐ Expiry date: _____/20_____

Are you vaccinated against COVID-19? (please circle one) **Yes / No**
Please note you must be fully vaccinated to attend sessions in person

If yes, how many does have you had? _____

Do you have a Health Care Card or Pension? **Yes / No**

If yes, what type: _____

Pension Number (if appropriate): _____

Veteran's Number (if appropriate):_____

(please turn the page)

Do you have funding from one of the following? **NDIS / TAC / WorkSafe / No**

If yes, Membership number: _____

Plan manager name (if applicable): _____

Plan manager email: _____ Phone number: _____

Do you have private health insurance? **Yes / No**

Who is your insurer? _____

Membership number: _____

What level of cover do you have? _____

Does this level cover psychological services? **Yes / No**

Do you have ambulance cover? **Yes / No**

Do you have a referral for your treatment? **Yes / No**

Name of referring doctor: _____

Address of referring doctor: _____

_____ Postcode: _____

Phone number of referring doctor: _____ Email: _____

Do you have a GP mental health care plan? **Yes / No**

If you answered no, please be aware that you cannot claim any Medicare rebate for your psychology sessions

If the following is the same as referring doctor, please write as above.

Name of GP: _____

Address of GP: _____

_____ Postcode: _____

Phone number of GP: _____ Email: _____

(please turn the page)

Do you have a neurologist? **Yes / No**

If the following is the same as referring doctor, please write as above.

Name of neurologist: _____

Address of neurologist: _____

_____ Postcode: _____

Phone number of neurologist: _____ Email: _____

Do you have a psychiatrist? **Yes / No**

If the following is the same as referring doctor, please write as above.

Name of psychiatrist: _____

Address of psychiatrist: _____

_____ Postcode: _____

Phone number of psychiatrist: _____ Email: _____

Consent to contact your next of kin in an emergency: **Yes / No**

Next of Kin Name: _____

Relationship to You: _____

Next of Kin phone number: _____Email:_____

Other relevant information:

_____

_____

_____

_____