

New Patient Intake Form

Please complete and bring to your first appointment.

Section 1: Personal details

Full name _____

Preferred name _____ Date of birth (___/___/___)

Sex recorded at birth (Female / Male / Intersex / Prefer not to say)

Gender identity (optional) _____

Mobile _____ Phone (home/work) _____

Email _____

Preferred contact method: Phone SMS Email Letter

Consent to SMS/email reminders: Yes No

Section 2: Address

Street address _____

Suburb _____ State _____

Postcode _____

Section 3: Medicare and cover

Medicare number _____ Expiry (MM/YY) _____

Individual reference number (IRN) _____

Private health fund (if any) _____

DVA number (if applicable) _____

Aboriginal or Torres Strait Islander origin (optional): Yes No Prefer not to say

Interpreter required: Yes No Preferred language: _____

Section 4: Emergency contact

Emergency contact name _____ Relationship _____

Emergency contact phone _____

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Additional details

Section 5: Referring practitioner (if applicable)

Referrer name _____ Practice _____
Referrer phone _____ Referrer email _____

Section 6: Appointment details

Reason for visit (brief) _____

Preferred appointment days/times _____
Any accessibility needs _____

Section 7: Consent

I confirm the information provided is accurate to the best of my knowledge. I understand that treatment options and recommendations will be discussed during consultation.

Signature _____ Date (DD/MM/YYYY) _____

Office use only

Referral source _____ Intake received _____