



NEW PATIENT FORM

Elmwood Medical / Complete Veteran Health

Patient Details

Title Mr Mrs Ms Miss Other: _____

First Name (Legal): _____

Surname (Legal): _____

Preferred Name: _____

Date of Birth: ___ / ___ / ___

Occupation: _____

Birth Sex: Male Female

Gender Identity: _____

Pronouns: _____

Ethnicity: Australian (non-Indigenous) Aboriginal Torres Strait Islander Both
Other: _____

Contact Information

Street Address: _____

Home Phone: _____

Mobile Phone: _____

Email: _____

Medicare / DVA Details

Medicare Number: _____ Ref: __ Expiry: ___/___

Concession / Pension / DVA Card Number (if applicable):

Card Type: _____ Expiry: ___/___

Are you a current ADF member? Yes No

If no, Discharge Date: ___/___/___



Emergency Contact

Next of Kin: _____ Phone: _____ Relationship: _____

Emergency Contact Same as Above? Yes

If not:

Name: _____ Phone: _____ Relationship: _____

Medical Information

Height (cm): ____ Weight (kg): ____

Allergies:

No known allergies

Yes – Please list: _____

Family Medical History

No significant family history

Yes – Please tick any that apply:

Mother: Diabetes Hypertension Heart Disease Stroke Cancer Other: _____

Father: Diabetes Hypertension Heart Disease Stroke Cancer Other: _____

Marital Status: Married Single Divorced De facto Widowed

Lives With: Spouse Parents Relative Friend Alone Carer

Alcohol Consumption: Non-drinker Days/week: ____ Drinks/day: ____

Smoking Status: Non-smoker Ex-smoker Smoker – Cigarettes/day: ____

Communication Preferences

Preferred Method for Communication:

Phone SMS Email Letter

PATIENT CONSENT

At Elmwood Medical / Complete Veteran Health, we are committed to protecting your privacy in accordance with the Privacy Act 1988 (Cth).



By signing this form, you acknowledge and agree to the following:

1. Your personal and health information is collected to provide you with appropriate care and services.
2. This information may be shared with relevant health providers involved in your treatment (e.g. specialists, hospitals, DVA).
3. Consent to DVA CVC program if eligible.
4. You can request access to your records or withdraw consent at any time.
5. You understand that DVA patients with Gold or White cards are bulk-billed for eligible services. We will assist with DVA paperwork and approvals where necessary.
6. After your initial in-person appointment, Telehealth services are available and covered by DVA (if related to accepted conditions and within Australia).
7. We offer after-hours and weekend care aligned with Elmwood Medical Centre opening hours.
8. You may receive SMS/email reminders, health information, or updates unless you opt out.

Mandatory Acknowledgement

I have read and understand Elmwood Medical's and Complete Veteran Health's privacy and consent policy

I understand my billing status (bulk-billed if eligible under DVA, otherwise private fees may apply)

I agree to provide at least 24 hours' notice for appointment cancellations or pay a cancellation fee as per clinic policy

Patient Name: _____

Signature: _____ Date: __/__/__

(Parent/Guardian if under 16): _____