Power Medical Centre
2/90 West Street
Busselton WA 6280
Phone: 9752 9555
Fax: 9752 9556
ABN : 79 604 641 625

CHANGE OF DETAILS FORM

This information is private and confidential and is for use in your clinical file only

Personal Details:					
Title	Mr Mrs Ms Miss Dr Other:				
Surname			**Date of Birth**		
First Name			**Middle Name**		
Street Address			**Preferred Name**		
Suburb			**Post Code**		
Postal Address:					
Phone / Home :		**Work :**	**Mobile:**		
Email Address:			**Consent to SMS Reminder?** Yes No		
Preferred Contact Method: (Please circle)	Home phone	Work phone	Mobile phone	Email	SMS
Occupation:			**Marital Status :**		

Emergency Contact Details:		
Next of Kin (Full Name):	**Contact Number:**	**Relationship:**
Emergency Contact (Full Name):	**Contact Number:**	**Relationship:**

By becoming a patient of Power Medical Centre and signing this new patient form I agree and consent to the following:

- I consent to the use of my personal health information by **Power Medical Centre** and other health care providers involved in my medical treatment and health care within this centre.
- I declare that the above details as completed have recently changed and this information should be used in addition to the new patient registration form completed at my first visit to Ravenswood Family Practice.
- I consent to the disclosure of my personal health information by the above named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.
- As part of preventative health services offered by this practice we send out follow up reminders and recalls when routine investigations are due. I consent to receive follow up reminders and recalls to be sent through my preferred method of contact.

Signature____ Date_______/________/________

Printed Name _____________________________________ (If the patient is under 16 years the parent/guardian is to sign)