

New Patient Questionnaire



Turn the Corner

Do any of your family members currently attend Turn the Corner Medical Clinic?

1. Relationship to you:
2. Relationship to you:
3. Relationship to you:

Some optional questions

Occupation: Hours per week:

Sexuality: Heterosexual Homosexual Bisexual Other

Prefer not to disclose

Communication from Turn the Corner

- We operate a recall system for matters of clinical significance. We send appointment reminders and secure links to certain test results via SMS if we have your mobile phone number on file.
- We participate in a personalised reminder program for preventive health issues such as skin checks and annual health assessments. We also produce an e-newsletter every month or so with Clinic information and relevant general health information to our clients.

If you do **NOT** wish to receive reminders and emails please tick this box

Under 16s only – Parent / Guardian details

First Name: Last Name: DOB: DD/MM/YYYY

Medicare No: |__|__|__|__| |__|__|__|__|__| |__| Ref. No: |__| Exp: MM/YYYY

Finally – your agreement

"I have read and agree to the Clinic's Terms and Privacy policy (available on the website), and agree to pay the fees associated with the services I receive or ask to receive from Turn the Corner Medical Clinic".

Signature:.....

Date: DD/MM/YYYY

of Patient, or of parent/guardian if Patient is less than 16 years of age.

Thank you. Please return this form to Reception - reception@turnthecorner.com.au