Patient registration form

Personal details

Title _____ Surname _____

First name _____ Middle name(s) _____

Sex: Male ___ Female ___ Other ___ Date of birth ____ / ____ / _____

Medicare No __ __ __ __ __ __ __ __ __ __ Ref No (left of name) ____ Exp Date ___ / _____

Pension/Centrelink HCC No _____ Exp Date ___ / _____

DVA No _____ Gold ___ White ___ Other ___ Exp Date ___ / _____

Street address _____

Suburb _____ State _____ Postcode _____

Email _____

Ph: Mobile _____ Home _____ Work _____

Marital status: Single ___ Married ___ Divorced ___ Separated ___ Widow ___ De facto ___

Please ensure the remainder of this section is all completed

Allergies: Yes ___ No ___ **If yes,** please list: _____

Do you smoke? Yes ___ No ___ Ex-smoker ___ **If ex-smoker** when did you quit? _____

Do you drink alcohol? Yes ___ No ___

If yes, how many days a week? _____ how many standard drinks per day? _____

Are you: Aboriginal ___ Torres Strait Islander ___ Neither ___

If neither, what is your ethnicity? _____

Next of kin

Name _____ Relationship _____ Phone: _____

IN CASE OF EMERGENCY (if different to next of kin)

Name _____ Relationship _____ Phone: _____

Contacting you / other parties

Your preferred contact method: Email ___ Letter ___ Phone ___ SMS ___

Do you consent to receiving appointment reminders via sms? Yes ___ No ___

Is your visit related to workers compensation or a third-party injury? Yes ___ No ___

Patient/carers signature _____ Date _____