Everton Hills
MEDICAL CENTRE

Patient Registration Form

Please have all details filled in correctly and clearly to ensure we can provide the best care possible. It is essential that your health record is accurate and up to date.

Personal Details

Title: □ Mr. □ Mrs. □ Miss. □ Ms. Marital Status: _____

First Name:_____ Known as:_____ Full Surname:_____

Date of Birth: _____ Sex: □ Female □ Male

Medicare Number: _ _ _ _ _ _ _ _ _ _ _ Ref# (to left of Name on Medicare Card) _____ Exp date: _____

Address:_____

Phone: _____ Work No: _____ Mobile: _____

Email (Please print in capitals): _____@_____ Occupation: _____

Cultural Background (i.e. Country of birth): _____ Year of Arrival: _____

To assist with Health Initiatives, are you: Aboriginal: □ Yes □ No Torres Strait Islander: □ Yes □ No

Allergies known: _____ Diseases Known: _____

Pap Smear (if female), year and month last had: _____ Was it Negative: □ Yes □ No

Do you Smoke: □ Yes □ No Have you ever smoked: □ Yes □ No Height: _____ Weight: _____

DVA File #: _____

Pension Card #: _____ Exp date: _____ /_____ /_____

Health Care Card #: _____ Exp date: _____ /_____ /_____

Private Health Insurance: □ Yes □ No Name of Health Fund: _____

Type of Cover: □ Bronze (Basic) □ Silver (Intermediate) □ Gold (Top Cover)

Next of Kin

Full Name: _____ Relationship: _____

Address: _____

Phone: _____ Mobile: _____

Emergency Contact (if different from next of kin, a person we can contact if needed)

Full Name: _____ Phone: _____Mobile: _____

Relationship: _____

Consent

By signing this form, I acknowledge that I have read the Privacy and Confidentiality Policy ***(located at front reception)*** *and understand the requirements of the Everton Hills Medical Centre and myself in how to manage my personal information whilst attending Everton Hills Medical Centre.*

Signature: _____ Date: _____

Practice Use Only:

Entered Info □	Date:_____	Initial:_____	Photo ID Sighted: □ Yes □ No	ID: _____
Scanned □	Date:_____	Initial:_____		