# PATIENT REGISTRATION FORM

***Please complete this form with BLOCK LETTERS. This will assist us in providing you with the best possible care. Fields marked with an * are required.***

*** Have you or any member of your family attended here before? Yes / No**

| ***Surname** | ***First Name:** | **Preferred Name:** |
|---|---|---|

***Address**

**Postcode**

| ***Date of Birth** | **Sex** |
|---|---|

Tel (Home)

Tel (Work)

Mobile

Email

**Can we send your test results and other correspondence to this email address?** **Yes / No**
**Can we send referrals & other correspondence by email to hospitals, doctors and other health professionals?** **Yes / No**
**Can we send text message appointment reminders, test results and other correspondence to your mobile phone?** **Yes / No**
We send information to Cervical Cytology & Immunisation Registers. To opt out discuss with your Doctor or Practice Nurse.

| ***Medicare No** | ***Ref No (Number beside name)** | ***Expiry Date** |
|---|---|---|

Pension or Health Care Card No — Expiry Date

Veterans Affairs No

OSHC Policy No

Relationship Status

Partner's Name — Partner's Date of Birth

***Person to contact in emergency** — ***Tel**
Next of Kin (if different to above) — Tel

**Employment** Are you employed? Yes / No

Occupation

Employer

Address

Do you identify as **Aboriginal**? Yes / No Do you identify as **Torres Strait Islander**? Yes / No

Country of Birth — Language spoken at home

**Family members living with you**

| Name | Relationship | Date of Birth | Country of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Do you have a **My Health Record?** Yes / No
If Yes, do you consent to us uploading a Medical Summary? Yes / No

Do you have a **Medical Decision Maker** (Medical Power of Attorney)? Yes / No
Do you have an **Advanced Care Directive**? Yes / No

| ***Your Name (printed)** | ***Signature** | ***Date** |
|---|---|---|