BANNOCKBURN SURGERY

Patient Registration Form

This information is important to ensure a high level of medical care. We respect your privacy and all information provided remains confidential as per the Information Privacy Act (2000).

PATIENT DETAILS			
Title	Surname	Given name(s)	Preferred Name “ “
DOB / /	Gender: ❑ Male ❑ Female ❑ Other_____ Identify: ❑ He ❑ She ❑ They		Occupation
Street Address	Suburb	State	Postcode
Postal Address (If different from above)	Suburb	State	Postcode
Mobile	Home	Work	Email
Ethnicity/Cultural Background	Language	Are you: ❑ Aboriginal ❑ Torres Straight Islander ❑ Both ❑ None	

NEXT OF KIN		
Full Name	Phone Number	Relationship to Patient

PERSON RESPONSIBLE FOR ACCOUNTS			
❑Patient ❑Other	Full Name	Relationship	DOB (if patient under 18 years)

HEALTH INSURANCE	
Medicare Number Ref No Exp	Health Insurance ❑ Yes ❑ No Provider: Number:
Pension /Health Care Card ❑ Yes ❑ No Number: Exp:	DVA ❑ Yes ❑ No Number: Colour:
Is your condition related to Workcover❑ Yes ❑ No Employer: Claim Number:	Is your condition related to TAC ❑ Yes ❑ No Insurer: Claim Number:
Specialists / Other Doctors Treating you:	

MEDICAL HISTORY
Allergies ❑ Nil Known ❑ Yes: Do you Smoke? ❑ No ❑ Yes: Per Day Do you consume Alcohol? ❑ No ❑ Yes / How Often? How many std per day?
Medical History:
Family History (eg diabetes, heart disease):
Current Medications:

CONSENT

- I certify that the above information is correct. In signing below, you agree to our Privacy Policy on the collection of your personal information and in the event of a debt you agree to pay any commission generated on the debt collected on your behalf by our nominated debt collection agency.
- I consent SMS reminders for appointments, clinical reminders, clinical communication and health awareness and electronic communication at my request.
- I consent for your information to be shared with other health providers

Name	Signature	Date / /