

Patient Registration Form

Welcome to our practice. It is vital to have the following information which will be handled confidentially.

Title	☐ Mrs ☐ Ms ☐ Miss ☐ Dr			
Given Name				
Family Name				
Preferred Name				
Address				
		Postcode		
Date of Birth				
Telephone	H:		M:	
E-mail address				
Medicare Card No		Ref no	Expiry date	
Private Health Insurance	☐ Yes ☐ Uninsured			
	Fund name		Membership#	
Referring Doctor		Usual Doctor + Medical Practice		
Occupation				
Emergency contact	Name		Relationship:	
	Telephone			

Consent to release information under Privacy Act 1988

I provide my consent for my doctor to collect, use and disclose my personal information to aid in my treatment.
I understand that I may withdraw my consent as to the use and disclosure of my personal information (except when legal obligations must be met).

Patients Name: _____ Signed _____

Date _____