

Melbourne City Medical Centre New Patient Registration Form

Fitle (Mr/Mrs/Miss/Dr):Fir	st Name:	Surname:
Date of Birth://_	Male / Female:	Occupation:
Address:		
		Postcode:
Contact Phone No. (Home):	(Mobi	le):
(We communicate via	mobile to inform you of appointm	nents and reminders for health prevention initiatives).
Allergies:		
Medicare No:	Ref. No:	Expiry:
OSHC (<u>Allianz</u>) Card Member N	(o:	Expiry Date:/
Concessions: Health Care Card	No:	Expiry Date:/
(Centrelink) Pensioner Card N	0:	Expiry Date:/
Veteran Card No:		Expiry Date:/
Country of Birth:	Ethnicity:	s
Email Address:		
Select if you would like to be iden	tified by your cultural backgr	round: N/A Aboriginal / Torres Strait Islander
Next of Kin:		
Name:	Contact No:	Relationship:
Emergency Contact:		
Name:	Contact No:	Relationship:
If different from next of kin contact)		
How did you hear about us? 🗌 1	Internet 🗌 Walking Past 🔲	Word of Mouth Referred by Existing Patients
	Personal Information	on Consent Form:
nformation collected by your doctor will be	e used to provide you with quality pati	ent care. Your personal health information will be keep confidential and v
ot be disclosed, unless required by law, to	any third party without your consent e	either verbally or in writing. I consent to the collection of medical information
or the purpose of providing me with quality	-	
	-	circumstances where access might legitimately be withheld. I understand
vill be given explanation in these circumsta	nces.	

Patient / Guardian Signature: ______ Date: ______