Melbourne City Medical Centre New Patient Registration Form

Title (Mr/Mrs/Miss/Dr):_____First Name: _____ Surname:_____

Date of Birth: _____/_____/_____ Male / Female:____ Occupation:_____

Address: _____

Town/Suburb: _____ Postcode:_____

Contact Phone No. (Home):_____ (Mobile):_____

(We communicate via mobile to inform you of appointments and reminders for health prevention initiatives).

Allergies: _____

Medicare No: _ _ _ _ _ _ _ _ _ _ Ref. No: ___ Expiry: _____

OSHC (Allianz) Card Member No: _____ Expiry Date:_____/_____/_____

Concessions: Health Care Card No: _____ Expiry Date: _____/_____/_____

(Centrelink) Pensioner Card No: _____ Expiry Date: _____/_____/_____

Veteran Card No: _____ Expiry Date: _____/_____/_____

Country of Birth: _____ Ethnicity: _____

Email Address: _____

Select if you would like to be identified by your cultural background: 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? ☐ Internet ☐ Walking Past ☐ Word of Mouth ☐ Referred by Existing Patients

Personal Information Consent Form:

Information collected by your doctor will be used to provide you with quality patient care. Your personal health information will be keep confidential and will not be disclosed, unless required by law, to any third party without your consent either verbally or in writing. I consent to the collection of medical information for the purpose of providing me with quality patient care.

I am aware of my rights to access information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given explanation in these circumstances.

Patient / Guardian Signature: _____ Date: _____