# Patient Registration Form

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|---|---|---|---|---|---|---|
| **Title** | Mr ☐ | Mrs ☐ | Ms ☐ | Miss ☐ | Master ☐ | Other: |

| | | | |
|---|---|---|---|
| **First Name:** | | **Middle Name:** | |
| **Surname:** | | **Also known as:** | |
| **Date of Birth:** | / / | **Gender:** Female ☐ | Male ☐ Other ☐ |
| **Medicare** | Number: | Ref # | Expiry Date:__/___ |
| **Cultural Identity** | Aboriginal ☐ | Torres Strait Islander ☐ | |
| | Aboriginal and Torres Strait Islander ☐ | Neither ☐ | |
| | Other ☐ (please indicate): | | |
| **Please note:** | we reserve the right to request confirmation of Aboriginality | | |
| **Pension** ☐ **HCC** ☐ | Number: | Expiry Date:__/__/___ | |
| **DVA Card** | Gold ☐ White ☐ Number: | Expiry Date:__/__/___ | |
| **Address:** | | | |
| | Town | Post Code: | |
| **Postal Address:** | | | |
| **(if different)** | Town | Post Code: | |
| **Contact details** | Mobile: | Work: | |
| | Home: | Email: | |
| **Next of Kin** | Name: | | |
| | Relationship: | Contact number: | |
| **Emergency** | Name: | | |
| **contact** | Relationship: | Contact number: | |
| **Marital Status** | | **Occupation** | |
| **Country of Birth** | | **Interpreter Required** Yes ☐ | No ☐ |
| **Travel** | Please tell us if you have been overseas recently, and where you travelled: | | |

***Allergies**: Yes ☐ No ☐ (please tell us what you are allergic to and the reaction below)

| Allergy | Reaction | Level e.g. minor/severe |
|---|---|---|
| | | |
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