Sale Medical Centre Patient Registration

UR:

Title:_____ Address 1:_____ DOB:_____

First Name:_____ Address 2:_____ Gender:_____

Surname:_____ Suburb:_____ Home Phone:_____

Middle Name:_____ State:_____ Work Phone:_____

Known as:_____ Country:_____ Mobile:_____

Maiden Name:_____ Email:_____

Medicare/DVA Number:_____Ref_____ ←*number next to your name*

Medicare Expiry_____Card Sighted ☐

HCC/Pension Number:_____ Expiry:_____

Indigenous Status

☐Aboriginal Origin ☐ TSI Origin

☐Neither ☐Registered for CTG

PBS Co-payment Relief

Marital Status

☐DeFacto/Partner ☐Divorced ☐Married ☐Separated

☐Same Sex Partner ☐Single ☐Widowed ☐Other

Cultural Information

Country of Birth:_____Year of Arrival if not Australia:_____

Primary Language:_____Ethnicity:_____

Employment

Occupation:_____

Employer:_____

Emergency Contact Information

Name_____

Phone:_____

Relationship to Patient:_____

Emergency Contact Information

Name:_____

Phone:_____

Relationship to Patient:_____

Payment is requested at the time of consultation

ID Sighted and copy on File:_____

Please read our Privacy Policy on the back of this form and sign.