Kedron Wavell Medical Centre Patient Registration Form

Title:	Mr Mrs Ms Miss Other		
Full Legal Name:		**Preferred Name:**	
Residential Address:			
		Postcode:	
Date of Birth:		**Gender:**	**Male / Female**
Phone - Home:		**Our practice uses a SMS service for appointment reminders and patient recalls.**	
Phone - Work:		**Aboriginal:**	Yes / No
Phone - Mobile:		**Torres Strait Islander:**	Yes / No
Occupation:		**Country of Birth:**	
Email:			
Medicare Card ☐ (Please Present at Reception)		**Veteran's Affairs Card ☐ (Please Present at Reception)**	
Health Care Card ☐ (Please Present at Reception)		**Pension Card ☐ (Please Present at Reception)**	
Health Insurance Fund:			

Next of Kin Details

Name		**Relationship:**	
Address:		**Contact Phone:**	
	Postcode:	**Enduring Power of Attorney:**	Yes / No

Emergency Contact Details

Name		**Relationship:**	
Address:		**Contact Phone:**	
	Postcode:	**Enduring Power of Attorney:**	Yes / No

I have been informed of the Surgery's Consultations Fees	Yes / No
Is this doctors visit in relation to a 1st time WorkCover Injury	Yes / No
Do you give consent to uploading information to My Health Record? You can register through Mygov. We will not upload documents without your consent.	Yes / No
I have read and understood the Kedron Wavell Medical Centre Privacy Policy and I also understand that I am not obliged to provide any information requested of me, but my failure to do so, might compromise the quality of health care and treatment given to me.	Yes / No

Have you been diagnosed with diabetes? Yes/No	Are you a smoker? Yes/No/Ex-Smoker
Have you been diagnosed with Asthma? Yes/No	

Patient/Guardian's Name:			
Signed:		**Date:**	

How Did You Hear About This Practice?

Signage ☐ Facebook ☐ Website ☐ Chemist ☐ Flyer ☐ Referral From Present Patient ☐ School Newsletter ☐

Family Member/s Already Attend ☐ Other ☐ Please specify(eg Hearing Clinic): ________________