EAST CORRIMAL MEDICAL CENTRE

17-19 Murray Road, East Corrimal, NSW: 2518, Phone: 0242844677

Patient Registration Form - CONFIDENTIAL INFORMATION

Date: ___ / ___ / _____ **Patient First Names:** _____ **Surname:** _____

Title: ☐ Mr. / ☐ Mrs. / ☐ Ms. / ☐ Miss / ☐ Master / Other: _____

Date of Birth: __ / __ / ____ **Gender:** _____ **Marital Status:** _____

Address: _____

Home Phone: _____ **Mobile:** _____ **Occupation:** _____

Email: _____

Allergies (please list) **Smoking** (cigarettes per day) **Alcohol Intake** (drinks per day)

_____ _____ _____

Next of Kin:

Full Name: _____ Relationship: _____ Telephone: _____

Emergency Contact:

Full Name: _____ Relationship: _____ Telephone: _____

Ethnicity:

To help with health initiatives, are you Aboriginal or Torres Strait Islander? _____

If No, please specify your ethnicity: _____

How did you hear about this Medical Practice? Google? Friend? Family? Other: _____

Consent: **Please tick**

☐ For us to inform securely to a Third party (e.g. Specialists/ Hospitals)

☐ For Recall letters/phone calls/SMS reminders, for further Medical Care

_____ _____

(Checked by Staff) Patient Signature

To be completed by Staff:

Medicare No. _____ IRN: ____ EXP. __ / __ / _____

Department of Veterans' Affairs No. _____ **CARD COLOUR**: _____

Pension Card No. _____ EXP. __ / __ / ___/

Health Care Card No. _____ EXP. __ / __ / _____

Private Health Insurance _____ NUMBER _____ EXP. __ / __ / _____