DAINTREE MEDICAL CENTRE

ABN 39 393 527 597

7 Daintree Way WEST WODONGA VIC 3690
**P**: 02 6059 2700 **F**: 02 6059 7500 **E**: admin@daintreemedical.com.au **W**: www.daintreemedical.com.au

# PATIENT REGISTRATION FORM

**PERSONAL DETAILS:**

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Gender: Male ☐ Female ☐

Surname: ______________________________ Given Name(s): ______________________________

Date of Birth: ______________________________ Nationality: ______________________________

Address: ______________________________________________________________________

Suburb: ___________________________________________________Postcode: _______________

Postal Address (if different from above): _________________________________________________

Suburb: ______________________________________________ Postcode: ____________________

Phone: (H) ________________________________ (W) ____________________________________

(M) ________________________________

Please **tick if you DO wish** to receive SMS reminders: ☐

Email:____________________________________________________________________________

**MEDICARE DETAILS:**

Medicare Number: ☐☐☐☐ – ☐☐☐☐☐ – ☐

Number in front of your name: ☐ Expiry Date: ☐☐ – ☐☐☐☐

**OTHER CONCESSION CARDS:**

Centrelink Health Care Y / N Card No: ___________________________ Exp Date: _________

Veterans Card Y / N Card No: ___________________________ Exp Date: __________

Pensioner Concession Y / N Card No: ___________________________ Exp Date: __________

**EMERGENCY AND NEXT OF KIN CONTACT DETAILS:**

Next of Kin: Name:_________________________________________________________________

Relationship:___________________________________Phone:______________________________

Emergency contact person: Name: _____________________________________________________

Relationship: __________________________________Phone: ______________________________

**DECLARATION:**

Are you or do you identify as Aboriginal ☐ or Torres Strait Islander? ☐ NO ☐

Do you have difficulty understanding or managing your medication use? YES ☐ NO ☐

Do you have any known allergies to medications or food? YES ☐ NO ☐

If yes please specify: _______________________________________________________________

Usual General Practitioner: _______________________ Medical Practice: ___________________

**CONSENT:** *Certain information about me may need to be provided to other service providers. I understand the recommendations and I give my permission for the information to be shared as detailed above. Patients are also required to complete the* ***Daintree Medical Centre Patient Family / Social History*** *form.*

**SIGNATURE**:___________________________________________________**DATE**:________________