***Carnegie/Malvern Medical Centre Patient Registration Form***

*Please use BLOCK LETTERS*

**Title: Mr/Mrs/Ms/Miss/Master Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ Sex: Male ⃝ Female ⃝**

**Please Select One: Aboriginal ⃝ Torres Strait Islander ⃝ Both ⃝ Neither ⃝**

**Country of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnic Background \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you speak English Y / N Preferred Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Deaf Y / N Interpreter required Y / N**

**Medicare Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reference Number \_\_\_\_ Expiry Date \_\_\_/\_\_\_\_\_\_**

**Pension Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry Date \_\_\_\_\_/\_\_\_\_\_\_**

**Health Care Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry Date \_\_\_\_\_/\_\_\_\_\_\_**

**Veteran’s Affairs Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Suburb/Town \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Postcode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address (optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Next Of Kin**

**First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Known As \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact (Someone other than Next of Kin)**

**First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian (if child under16 years of age)**

**First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_**

**Medicare Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reference Number \_\_\_\_\_\_**

**Consent Form**

**I have read the Privacy information provided and I understand the reasons why my information must be collected and agree to that collection. ⃝**

**I understand that I am not obliged to provide any information requested of me, however, failure to do so may compromise the quality of health care and treatment given to me. ⃝**

**I have read the information provided on making my record available to EHealth and agree to the uploading of my information. ⃝**

**I have read the billing policy information provided to me and understand and agree to the cost of my consultation. ⃝**

**I consent to**

* **The sharing of my medical information with other authorised health professionals. ⃝**
* **Being part of the Recall/ reminder system for appointments and clinical follow up. ⃝**
* **SMS/Text messages being sent to my mobile phone. ⃝**

**I agree to a third party (e.g. medical students) being present during my consultation. I am aware that I can revoke that consent at the time of a particular consultation if I wish to do so. ⃝**

**Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_/\_\_/\_\_**

**Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**