Village Medical CENTRE

Registration form for new patients

ADMINISTRATION **(Please hand this page to our reception staff)** Today's date: ……

Title …… Surname ……

First name ……

Middle name ……

Your preferred name……

Date of birth ___ /___ /_____

Male ❑ Female ❑

Do you identify yourself as Aboriginal or Torres Strait Islander? Yes ❑ No ❑

Address ……

……

Suburb …… P/C ……

Please use the same name as shown on your Medicare card/ the name you use when attending pathology, radiology, etc. This is to ensure your results are received correctly.

Medicare Number:
❑❑❑❑ ❑❑❑❑❑ ❑
Line number ❑ Expiry date ___ /_____

……

DVA number: ❑❑❑❑❑❑❑
❑ Gold ❑ White ❑ Lilac ❑ Orange

……

Pension No. / Health Care Card No.
❑❑❑ ❑❑❑ ❑❑❑❑
Expiry date ___ /___ /_____

Concession card type:
❑ Pensioner Concession Card
❑ Health Care Card

		Please indicate your preferred contact number (✓tick)	Can a message be left at this number?
Home Ph			Yes ❑ No ❑
Work Ph			Yes ❑ No ❑
Mobile Ph			Yes ❑ No ❑
Email	……@……	Can this be used to send general information that may be relevant to you? Yes ❑ No ❑	

Who is responsible for payment of accounts? *(i.e. patient / parent / state trustees, etc)*
Name:
Contact Numbers:
Relationship to you:

Next of Kin *(if different from above):*
Name:
Contact Number:
Relationship to you:

Emergency Contact *(if different to Next of Kin):*
Name:
Contact Number:
Relationship to you:

How did you hear about our Practice? (please tick)
❑ friend or family recommended ❑ advertisement in local paper ❑ advertisement
❑ advertisement - letter box drop ❑ internet/ web site ❑ Yellow Pages ❑ pharmacist
❑ allied health professional (e.g. physiotherapist, nurse) ❑ other doctor