Botanical Gardens HEALTH

New Patient Registration Form

If you require a translator or assistance in completing this form please speak to reception

Title: **Family name:**

Given name: **Middle name:** **Preferred name:**

Date of birth: **Sex:**

Ethnicity: **Religion:**

Do you identify as Aboriginal? Yes / No **Do you identify as Torres Strait Islander? Yes / No**

Residential address: **Postal address:**

Home Phone: **Work Phone:**

Mobile Phone: **Contact via:**

Would you like an SMS reminder for your appointments? Yes / No

Medicare number: __ __ __ __ __ __ __ __ __ __ Reference Number: Expiry date:

Health Care Card number: __ __ __ __ __ __ __ __ __ __ Expiry date:

Pension number: __ __ __ __ __ __ __ __ __ __ Expiry date:

DVA card number. __ __ __ __ __ __ __ __ Expiry: Colour of card: Conditions:

<u>Additional Family Members</u> – Please see reception before completing this section

Name: Date of Birth: Medicare Number: __ __ __ __ __ __ __ __ __ __ __

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<u>Please note: We only bulk bill those on a current Pension/HCC, Senior's Health Care Card, and children under 16</u>

Health Fund:
Name: Number:

Occupation: **Employer:**

Head of family (if child):

Next of kin: Name: Relationship: Telephone number:

Emergency Contact: Name: Relationship: Telephone number:

<u>For on call patients</u>
<u>Name, address and phone number of usual doctor:</u>

I give consent to Botanical Gardens Health collecting and storing my personal information in accordance with the Botanical Gardens Health Patient Practice Privacy Policy

Signed: _____ **Date:** _____