



Service Street MEDICAL CENTRE

If you identify as an Aboriginal or Torres Strait Islander, are you registered for "Closing the Gap" PBS co-payment relief? **YES/NO**
(If no and you are interested in finding out more information or registering please ask at reception)

- Aboriginal
- Torres Strait Islander
- Neither

Other ethnicity (for our records only): _____

Mr/Mrs/Miss/Ms Surname: _____

Given Name/s: _____

Preferred Name: _____

Date of Birth: ____/____/____

Address: _____

Suburb: _____

Postcode: _____ State: _____

Home Phone: _____

Mobile: _____

Work Phone: _____

Email: _____

Occupation: _____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Telephone: _____

Do you give permission for us to contact the above person in the event that we cannot reach you? **YES/NO**

Billing Information:

- Medicare card
- DVA Card

Card Number: _____

Reference Number: _____ Expiry: ____/____/____

- Pension Card
- Health Care Card

Card Number: _____

Reference Number: _____ Expiry: ____/____/____

Do you require your records to be transferred from your previous medical practice? **YES/NO**

Name of Medical Centre: _____

Telephone: _____

I hereby consent to being a patient at the Practice and I confirm that I agree to observe all the Practice Policies and Procedures

Signature: (if over 16 or Parent/Guardian) _____ Date: _____

Medical History:

Have you had any of the following appointments? If yes please provide the date.

Chronic Disease Management Plan ____/____/____

Health Assessment 45-49/75+ ____/____/____

Mental Health Care Plan ____/____/____

Please list any allergies in particular to medications. If you do not have any allergies write "Nil"

Allergies:	Reactions: