Donnybrook Medical Services

New Patient Registration Form

Please complete the following form, please ensure all spaces are completed and return to reception.

Patient Information

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Master ☐ Dr ☐ Other _____

First Name: _____ Surname:_____ Preferred Name:_____

DOB: ____ / ____ / _____ Gender: ☐ Male ☐ Female ☐ Other

Home Ph: _____ Work Ph: _____Mobile: _____

Are you happy to receive an SMS message for reminders?: ☐ Yes ☐ No

Address: _____ Suburb: _____ State: ____ Postcode:_____

Do you identify as Aboriginal or Torres Strait Islander?

(Please tick if appropriate) ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Ethnicity (E.g. Australian, Italian, American etc.): _____

Country of Birth: _____

Next of Kin

Next of Kin (Name): _____ Phone: _____

Relationship: _____

If same as above: ☐ *(Please Tick)*

Emergency Contact: _____Phone: _____

Relationship: _____

Medicare Card Details

Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Reference Number: ____

Exp. Date: ____ / _____

Concessions

☐ None ☐ Health Care Card ☐ Pensioner ☐ Veteran *(If yes, please specify type)* ☐ White ☐ Gold

☐ Other

Card Number: _____

Exp. Date: ___ / ___ / _____

Please present any of the above cards to reception when returning this form

The information you give us about yourself is essential for administration, investigations and the management of your health. The information will be kept confidential and will not be released to any individual or organisation without your consent, except when we are obliged by law to notify the Department of Health and Ageing for disease notification as per the Privacy Policy displayed.

Signed: _____ *(Patient or parent/legal guardian if under the age of 18 years)*

Date: ____ / ____ / _____