New Client Registration Form

Date_____/_____/_____

PERSONAL INFORMATION

GIVEN NAME: _____

FAMILY NAMES: _____

DATE OF BIRTH: _____/_____/_____

SEX: MALE / FEMALE

MOBILE NUMBER: _____

HOME PHONE NUMBER: _____

WORK NUMBER: _____

ADDRESS: _____

INDIGENOUS STATUS: ☐ ABORGINAL ☐ TORRES STRAIT ISLANDER

(Please tick) ☐ BOTH ☐ NON INDIGENOUS ☐ OTHER _____

PREVIOUS DOCTOR INFORMATION

NAME OF PREVIOUS DOCTOR: _____ PHONE NUMBER: _____

ADDRESS: _____

Clients will need to complete and sign, a medical records transfer request form

EMERGENCY CONTACT INFORMATION

NEXT OF KIN: _____ CONTACT DETAILS: _____

NAME OF EMERGENCY CONTACT PERSON: _____

PHONE NUMBER WITH EMERGENCY CONTACT: _____

RELATIONSHIP OF EMERGENCY CONTACT: _____

CARD INFORMATION

MEDICARE CARD NO: __ __ __ __ __ __ __ __ __ __ __ **REF NO**: ___ EXPIRY DATE: ____/_____

CONCESSION CARD NO: _____ EXPIRY DATE: ____/____/_____

PENSION CARD NO: _____ EXPIRY DATE: ____/____/_____

HEALTHCARE CARD NO: _____ EXPIRY DATE: ____/____/_____

Note: Information is used to set up client's electronic file. Registration sheet is to be scanned into client's file and then shredded.

Office Use: Operator Initials: __ __ __