Kenthurst Medical Centre

New Patient Registration Form

Personal Contact

Title: _____ (Ms, Mr etc.) **First Name: _____ Middle Name: _____ Surname: _____**

Nickname(s) (If any) **: _____ Date of Birth** (DD/MM/YYYY)**: ____ / _____ /_____ Sex: _____**

Address: _____ City/Suburb: _____ Postcode: _____

Home Phone: _____ Mobile Number: _____ Work Number: _____

Email Address: _____

Consent to SMS Appointment Reminders: Yes ☐ **No** ☐

Background

Are You of Aboriginal or Torres Strait Islander Origin? No: ☐ **Yes:** ☐ If yes, specify: _____

Ethnicity: _____ Religion: _____ Occupation: _____

Next Of Kin

Title: _____ (Ms, Mr etc.) **First Name: _____ Surname: _____**

Address: _____ City/Suburb: _____ Postcode: _____

Best Contact Number: _____ Alternate Contact Number: _____ Relationship to You: _____

Emergency Contact

Same as Next of Kin: Yes ☐ **No** ☐ If no, please fill out below:

Title: _____ (Ms, Mr etc.) **First Name: _____ Surname: _____**

Address: _____ City/Suburb: _____ Postcode: _____

Best Contact Number: _____ Alternate Contact Number: _____ Relationship to You: _____

Billing

Medicare: ☐☐☐☐☐☐☐☐☐☐ **Reference No.** ☐ **Expiry Date:** ☐

NB: Reference No. is left of your name, indicating order

Pensioner: ☐☐☐☐☐☐☐☐☐☐ **Expiry Date:** ☐

Health Care: ☐☐☐☐☐☐☐☐☐☐ **Expiry Date:** ☐

NB: Private health insurance is not required

DVA No. : ☐☐☐☐☐☐☐☐☐☐ **Expiry Date:** ☐

Colour of DVA Card (Please Circle)**: Gold Orange White**

I consent to the collection and use of the above information at Kenthurst Medical Centre

Signature: _____ (Guardians of underage children, specify relationship _____) **Date** (DD/MM/YYYY)**: ____/_____/_____**