Hall Road Medical Centre - Patient Registration Form

The Doctors and Staff at this clinic are committed to total patient care. This information will be treated confidentially.

Thank you for your assistance.

Personal Information Title	Mr Mrs Ms Miss Dr Other ....
First Name	....
Surname	....
Name known by	....
Address	....
Suburb/Postcode	....
Date of Birth	....
Home Phone	.... Mobile: ....
Email Address	....
Medicare Number	.... Ref: ....
Centrelink Concessions Concession/Pension Number	❒ Health Care Card ❒ Pension ❒ DVA .... Expiry: ....
Are you Aboriginal or Torres Strait Islander?	If Yes, you may be entitled to increased Medicare benefits ❒ No ❒ Torres Strait Islander ❒ Aboriginal
Your cultural background may increase your risk of certain illnesses.	Country of birth .... Language .... Do you require an interpreter ❒ Yes ❒ No
Person you would like contacted in an emergency	Name .... Relationship .... Phone/Mobile................................
Is this person also your 'Next of Kin'?	❒ Yes ❒ No If no, who is your next of kin? Name .... Relationship .... Phone/Mobile ....

SMS Messages for Reminders/Recalls

Do you consent to receive SMS messages on your mobile phone in relation to appointment reminders or health reminders/recalls? If yes, we must obtain your consent. Yes No

Do you consent to us sharing medical information with <u>other health professionals</u>? Yes No

If all details above are correct, please sign below and **RETURN** form to Reception when complete.

Signature.. **Date** ....

<u>APPOINTMENTS CAN ALSO BE MADE THROUGH OUR WEBSITE, FACEBOOK OR HOTDOC</u>

<u>PLEASE NOTE: WE REQUIRE 24HOUR NOTICE TO CANCEL/CHANGE AN APPOINMENT.</u>

<u>THERE WILL BE A MIN $20.00 FEE IMPOSED IF WE DO NOT GET ANY NOTIFICATION. THANK YOU</u>