EASTBRUNSWICK MEDICAL CENTRE

We are committed to providing you with excellent Health Care

New Patient Registration Sheet

☐ Dr A Rutherford ☐ Dr C Veith ☐ Dr A Wright ☐ Dr A Carter

☐ Dr H van Doorn ☐ Dr K Parker ☐ Dr A Osborne ☐ Roz O'Reilly

☐ Virginia Tregonning

Title: _____ NAME: _____
(Mr/ Mrs/ Ms/ Miss/ Dr) (Surname) (First Name)

ADDRESS:_____

Suburb: _____Postcode: _____

D.O.B: _____ / _____ / _____

Contact Phone No.(h): _____ (mob.): _____

(We communicate by SMS or by post in relation to appointments, reminders for preventative health activities– tick if you do NOT wish to receive communications from up.) ☐

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ __ Ref No:____ Expiry:_____

Pensioner Card No: _____Grant Date: ___/___/___Expiry____/_____

Health Care Card No: _____ Grant Date: ___/___/___Expiry____/_____

Veteran Affairs Card No: _____ Type_____Expiry:____/_____

Do you identify as Aboriginal and Torres Strait Islander: ☐ Yes ☐ No

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

Country of Birth: _____Ethnicity: _____

Email Address:_____

(We may contact you via this email address for newsletters or health promotion activities Tick if you do NOT wish to be contacted via email.) ☐

Marital Status: ☐ Married ☐ Single ☐ Seperated ☐ Partner ☐ Defacto ☐ Divorced ☐ Widowed

How did you hear about us?

☐ Word of Mouth ☐ Internet ☐ Referred by Existing Patients ☐ Phone Book

☐ Walking Past

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Occupation:_____

Next Of Kin:

Name: _____Contact No: _____Relationship: _____

Emergency Contact:

Name: _____Contact No: _____Relationship: _____
(If different from next of kin contact)

Personal Information Consent Form:

Information collected by your doctor will be used to provide you with quality patient care. Your personal health information will be kept confidential and will not be disclosed, unless required by law, to any third party without your consent either verbally or in writing. I consent to the collection of medical information for the purpose of providing me with quality patient care.

I am aware of my right to access information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given explanation in these circumstances.

Patient's Signature/Guardian _____Date:_____

Office Use Only
Completed By:_____ Patient File Number:_____ Date:_____