TOTAL HEALTH MEDICAL

11/1 Swordfish Avenue, Taranganba Q 4703
P 07 4939 1888 | F 07 4939 1433
20 Pattison Street, Emu Park Q 4710
P 07 4807 6510 | F 07 4910 5237

# NEW PATIENT REGISTRATION FORM
## ** PHOTO ID TO BE SHOWN TO RECEPTION **

Title: _____ First Name: _____ Surname: _____

Known As: _____ Date of Birth: _____ Sex: Male ☐ Female ☐ Transgender ☐

Are you of: Aboriginal origin ☐ Torres Strait Islander origin ☐ Aboriginal & TSI origin ☐ Neither ☐

Ethnicity: *eg African, Asian, Caucasian, European, Oceanian (Aust, NZ, Melanesian, Papuan, Polynesia)* _____

**Details of Guardian or Parent (if patient is under the age of 16)**:

Full Name: _____ DOB: _____

Relationship: _____ Phone: _____

Address: (home) Street - _____

Suburb: _____ State: _____ Postcode: _____

**Phone: (home):** _____ **(work):** _____ **(mobile):** _____

Address: (home) Postal - _____

Suburb: _____ State: _____ Postcode: _____

Opt OUT of SMS: *Tick this box if you do **NOT** wish to receive SMS reminders regarding appointment times and recalls* * ☐

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Defacto ☐ Separated ☐

Occupation: _____ Country of Birth: _____

*Next of Kin* -

Name: _____ Relationship: _____

Phone: _____

*Emergency Contact* -

Name: _____ Relationship: _____

Phone: _____

Signature: _____ Date: _____

*Office use only*

*Medicare Card Number:* _____ *Reference Number:* _____ *Expiry Date:* _____

*Concession Card Type: (Vets/Pens/HCC)* _____

*Card Number:* _____ *Expiry Date:* _____

***Photo ID document type:*** _____ ***Copy attached:*** _____

**SMS reminders are sent directly from Total Health – therefore your information is NOT shared with a third party*