NEW PATIENT REGISTRATION FORM

** PHOTO ID TO BE SHOWN TO RECEPTION **

Title: _____ First name: _____ Middle name: _____

Surname: _____ Known as: _____ Date of birth: _____

Sex at birth: ☐ Not stated ☐ Male ☐ Female ☐ Intersex/Other Transgender: ☐

MyMedicare registered status: _____

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: _____

Email: _____

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*