CHASE MEDICAL CENTRE PATIENT REGISTRATION

PLEASE ENTER YOUR NAME AS IT APPEARS ON YOUR MEDICARE CARD (If applicable)

TITLE : ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other..

SURNAME: **GIVEN NAME (S):**

MIDDLE NAME (S): **PREFERRED NAME**:

DATE OF BIRTH: ………/……../………….

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ DE FACTO ☐SEPARATED ☐WIDOWED

ADDRESS:

CONTACT: MOBILE: …………………………… **HOME**: ………………………… **WORK**: ………………………….

EMAIL ADDRESS: ……………………………………………………………………………………….

MEDICARE NUMBER: …………………………………………. **REF:** …… **EXP**: ……………

PENSION/HEALTHCARE/REPAT/VET AFFAIRS NO: ………………………………………………… **EXP**: ……….

OCCUPATION: ……………………………………………………………………

COUNTRY OF BIRTH: …………………………………… **YEAR OF ARRIVAL IN AUSTRALIA** ……………

CULTURAL BACKGROUND: ……………………………. **ABORIGINAL AND/OR TSI:** ☐**YES** /☐ **NO**

NEXT OF KIN / **EMERGENCY CONTACT NAME:** ……………………………………………………………………………………

RELATIONSHIP: ……………………………………………. **PHONE:**………………………………………….

DO YOU HAVE ANY ALLERGIES? SENSITIVE TO DRUGS? DRESSINGS? ……………………………………………………………………………..

SMOKING: ☐ **YES** ☐ **NO** ☐ **PREVIOUSLY SOCIALLY**

ALCOHOL: Click here to enter text. **DRINKS PER** ☒**DAY** /☐ **WEEK** /☐ **MONTH (tick applicable)**

MEDICATIONS: **……..**

PLEASE FIND A COPY OF THE PRIVACY POLICY ON THE RECEPTION DESK