CHASE MEDICAL CENTRE PATIENT REGISTRATION

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

TITLE : Mr Mrs Ms Miss Other………

SURNAME: …………………………………………………………………………

GIVEN NAME (S): ………………………………………………**PREFERRED NAME**: …………………………………….

DATE OF BIRTH: ………/……../………….

MARITAL STATUS: SINGLE MARRIED DIVORCED DE FACTO SEPARATED WIDOWED

ADDRESS: ………

…………………………………………………………………………………………..POST CODE: …………………………..

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:** ………………………………………………………………………………

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

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

SMOKING: YES NO PREVIOUSLY SOCIALLY

ALCOHOL: ………………………………….**DRINKS PER DAY / WEEK / MONTH (circle one applicable)**

MEDICATIONS: ……………………………………………………………………………………………

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