A1 Doctors Surgery

Registration Form for New Patient

Title_____Surename_____

First Name_____ Middle Name_____

Preferred Name_____ Date of Birth_____

Gender _____ Aboriginal or Torres Islander_____

Ethnicity_____

Address _____

Suburb _____ State _____Post Code_____

Home Phone _____ Mobile Phone _____

Email _____

Medicare Number_____

Reference Number_____ Expiry Date _____/_____/_____

Veteran Affairs Number_____Color_____Expiry Date_____/_____/_____

Emergency Contact Person (Next of Kin)

Title_____ First Name_____ Surname _____

Relationship to you_____

Address _____

Suburb _____State _____Postcode_____

Home Phone _____ Mobile _____

REMINDER SYSTEM

Our Medical Clinic provides our patients with preventative care and early reminders, for example; immunization, Annual Health Checks, Pap smears and Annual Skin checks etc.

Do you wish to have any relevant health reminders sent to you? Yes/No

What is your preferred method of contact; Home Phone/Mobile/Mail/SMS (please encircle)

Signature_____

Print Full Name_____

Date_____/_____/_____