Maple Leaf
MEDICAL CENTRE

NEW PATIENT REGISTRATION FORM

Title: Mr Mrs Miss Ms Other Surname: _____

First Name: _____ Preferred Name: _____

Middle Name: _____ Date Of Birth: _____/_____/_____

Gender: Male Female Other Ethnicity: _____

* Are you of (please circle) - Aboriginal Torres Strait Islander Neither

Address: _____

Suburb: _____ State: _____ Postcode: _____

Home Phone: _____ Mobile: _____

E-mail: _____

Your Occupation(s): _____

Medicare Number: _____ Expiry Date: ___/_____ Reference Number: ___

Veteran Affairs Number: _____ Gold/White Expiry Date ____/____/____

Pension Card Type: Pension Card Health Care Care Senior Commonwealth Card

Card number: _____ Expiry Date ____/_____/_____

Next Of Kin:

Title: _____ First Name: _____ Surname: _____

Relationship to you: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Home Phone: _____ Mobile: _____

Emergency Contact:

Title:_____ First Name: _____ Surname: _____

Relationship to you: _____

Home Phone: _____ Mobile: _____

Are you a smoker: Yes No Ex-Smoker

Are you pregnant: Yes No

How did you hear about us?

Google Health Engine Facebook Word of Mouth Walking past

Our practice uses a recall and reminder system, if you do not wish to be contacted via sms or partake in this service please let reception know.

I understand that Maple Leaf Medical Centre complies with the privacy and data protection act 2014 and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information.

My signature below indicates that I have read the above and consent to Maple Leaf Medical Centre collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits: inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorised representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent to Maple Leaf Medical Centre to use and disclose my personal information (except when legal obligations must be met.)

Patient/Guardian Signature: _____ Date: _____/_____/_____