PATIENT REGISTRATION FORM

WELCOME TO THE YOU YANGS MEDICAL CLINC

We need this information to provide the best quality of care. Our clinic follows the guidelines of The Royal Australian College of General Practitioners Handbook for the management of health information in private medical practice. This means your personal health information is kept private and secure, as required by federal and state privacy laws.

PATIENT DETAILS

☐ Mr ☐ Mst ☐ Mrs ☐ Ms ☐ Miss Date of Birth: ____/____/____

Family Name: ______________________ Sex: ☐ Female ☐ Male

First Name: ______________________ Marital Status: ☐ Single ☐ Married ☐ Defacto

Preferred Name (if applicable): ______________ ☐ Separated ☐ Divorced ☐ Widowed

Address: ____

Telephone: Home ______________ Mobile ______________ Work ______________

Email: ____

Medicare Number: ______________ What number are you on the card: ____ Expiry: ____/____

Have you registered your **Bank Account Details** with Medicare for account claiming? ☐ Yes ☐ No

Health Care Card Number: ______________ Expiry: ____/____/____

Pension Card Number: ______________ Expiry: ____/____/____

Veterans Affairs Card Number: ______________ Expiry: ____/____/____

Next of Kin

Name: ______________________ Relationship to you: ______________

Telephone: Home ______________ Mobile ______________ Work ______________

Emergency contact (this is someone you are happy for the clinic to contact on your behalf in case of an emergency)

As above ☐ Yes ☐ No - Please fill in details below

Name: ______________________ Relationship to you: ______________

Telephone: Home ______________ Mobile ______________ Work ______________

Are you of Aboriginal or Torres Strait Islander origin? ☐ Yes ☐ No

If yes, ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

Please read and discuss with doctor if you have concerns

The clinic uses a recall and reminder system to improve quality of your health care; we send reminders by email, mail, SMS or telephone for procedures such as vaccinations, Pap tests and other health reviews.

Please indicate if you prefer ***not*** to be contacted as part of the quality improvement activities at this clinic ☐

Signature of patient or guardian: ______________________ Date: ____/____/____

*****Please advise us if your contact information or Medicare details change.*****