Dapto Healthcare
Medical Centre

Patient Registration Form

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Could you please assist us by providing the following information:

Are you Aboriginal or Torres Strait Islander? ☐ Yes - Aboriginal ☐ Yes- Torres Strait Islander ☐ Yes - Both ☐ No

Title ☐Miss ☐Mrs ☐Ms ☐Mr ☐Mast ☐Mx **First Name**

Surname

Preferred Name **Date of Birth**

Sex* *Please specify the sex assigned on your Medicare card, if you do not identify with this, please fill in boxes below

Gender Idenitity **Pronouns** ☐ She/Her ☐ He/Him ☐ They/Them

Medicare Number _ _ _ _ _ _ _ _ _ _ **Ref:** _ **Expiry Date**

Pensioner / Healthcare Number **CRN** _ _ _ _ _ _ _ _ _ _ **Expiry Date**

DVA ☐ Gold ☐White ☐ Orange **DVA Number** _ _ _ _ _ _ _ _ _

Street Address **Postcode**

Suburb *If you have a different postal address, please let the staff know when you hand in this paperwork.

Mobile Phone _ _ _ _ _ _ _ _ _ _ **Home Phone** _ _ _ _ _ _ _ _

Email

Ethnicity **Occupation**

Next of Kin

Next of Kin Number _ _ _ _ _ _ _ _ _ _ **Relationship**

Emergency Contact ☐ Same as next of kin

Next of Kin Number _ _ _ _ _ _ _ _ _ _ **Relationship**

Do you provide consent for the practice to contact you via SMS, Email or Mail for any recalls or reminders ☐ Yes ☐ No

I confirm that I have received a copy of the practice pamphlet and privacy statement:

SIGNATURE .... **DATE** ....

Thank you for your assistance in helping us provide quality care