Dr Timothy Ong
Dr Kerrie Malarkey
Dr John Hanrahan
Dr Talila Milroy

QUEENS PARK
MEDICAL CENTRE

NEW PATIENT REGISTRATION FORM

Patient Details:

Title ______ **Given Names** __________________ **Surname** __________________ (Preferred Name) ____________________

Date of Birth: ____/____/____ Male ☐ **Female** ☐

Are you of Aboriginal or Torres Strait Islander origin? Yes ☐ (If Yes, please specify below) **No** ☐

Aboriginal ☐ **Torres Strait Islander** ☐ **Aboriginal & Torres Strait Islander** ☐

Ethnicity ____________________________

Does the patient require a translator? Yes / No (If Yes; Please indicate which language) ____________________

Medicare Number ☐☐☐☐☐☐☐☐☐☐ **Ref Number:** ☐ **Expiry Date:** ☐☐ ☐☐

Concession Type: **Pension Card** ☐ **Health Care Card** ☐ **Veteran Affairs** ☐

Card Number: ☐☐☐ ☐☐☐ ☐☐☐ **Letter** ☐ **Expiry Date:** ☐☐ ☐☐ ☐☐

Patient's Home Address: ____

Suburb: ____ **Postcode:** ☐☐☐☐

Phone: (Home) __________________ **(Work)** _________________ **(Mobile)**_____________

Email: ________________________________

I consent for the practice to contact me via SMS for appointment reminders, recalls and other test reminders or medical services we offer *Yes / No* **Signature**: ____________________________________

Marital Status: Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed ☐

Occupation______________________ **Country of Birth**___________________ **Year of Arrival in Australia**______________

Next of Kin

Given Name: _______________________ Surname: __________________ Relationship to you__________________________

Phone :(Home)_________________ (Work)_________________________ (Mobile)_____________________________________

Emergency Contact – write '**AS ABOVE**' if next of kin and emergency contact are the same person.

Given Name: _______________________ Surname: __________________ Relationship to you__________________________

Phone :(Home)________________ (Work)________________________ (Mobile)______________________________________

How did you find out about us? ☐ Internet ☐ Family/Friend ☐ Newspaper ☐ Drove by ☐ Other

If other, please specify______________________

Privacy Patient Information

To provide high standard of medical care we need to collect personal information from our patients. This information is usually collected from the patient but may be collected from family members and other health care provider's with the patient's consent. At times some of the information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your personal health information are bound to confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your Doctor.

Signature of patient or guardian_ ________________________ Date _______ / _______ / 2019