Irymple MEDICAL CENTRE

3/2109-2111 Fifteenth Street
Irymple, VIC 3498
Ph 03 5024 5746, Fax 03 5024 6894

PATIENT REGISTRATION FORM

Please fill and circle where appropriate

Salutation: Mr/Mrs/Ms Other -------

Surname:----------Given Name:----------

DOB:……/……/……

Address: ----------

City---------- State---------- Postcode----------

Phone:----------Mobile----------

Medicare No:---------- Ref: ------- Expiry Date:----------/----------

Concession Cards: Yes/No Pension/HCC/Vet Affairs

Card Number: ---------- Expiry Date:----------/---------- CRN

Are you claiming Work Cover or TAC? Yes/No
Are you Aboriginal/Torres strait Islander? Yes/No
Your Country of Origin is: ----------

Next of Kin/Emergency contact
Name:
Phone: Mobile:
Relationship:
Do you wish to share your medical information with Partner/Husband, Family member or Friend? Yes/No
This practice sends SMS reminders if you do not wish to receive these messages please notify reception staff

Signature: ----------Date: --------/---------/----------

Practice Brochure's are located at reception, giving you details of practice policies and procedures. SMS reminders/appointment cards are given as courtesy only, patient are expected to remember appointment times. Patient who miss 3 appointments in a 12 months period will be made inactive. This practice does not use emails for appointment or correspondence of patient information.