202 Ontario Avenue
Mildura Vic. 3500
Ph: 03 50211 688
Fax: 03 5021 0266

Patient Registration & Information Form:

Title:	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other			
Surname:				
Given Names:				
Preferred Name:				
D.O.B		Ethnicity:		Gender:
Street Address:				
Postal Address: (if different to street)				
Phone Numbers:	Home:	Mobile:	Work:	
Email:				
Occupation:				
Medicare Number:		Ref No:	Expiry Date:	
DVA Gold/White:			Expiry Date:	
Pension/HCC Number:			Expiry Date:	
Religion:				
Next of Kin: (Name, Address & Telephone)				
Emergency Contact: (Relationship to you)	(Name and Telephone number of the person we can contact if needed)			

To assist us with health initiatives – are you of Aboriginal or Torres Strait Islander descent?

☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Aboriginal & Torres Strait ☐ No

Would you like to register for My Health Records? ☐ Yes ☐ No
(My health record will allow you to access a summary of your important health information online to share with other health professionals, which is fully controlled by you. Please ask staff for more information if interested)

Do you have any allergies or are you sensitive to drugs or dressings? ☐ Yes (please explain) ☐ No

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Do you have any kind of Private Health Insurance? Hospital cover (not ancillary)

☐ No
☐ Yes (**please list company & Cover type & Number**)

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By signing this form you understand all procedure's of the practice and agree to pay all accounts within the practice's specified time period. In the event of late payments the practice reserves the right to charge an account servicing fee.

Signed ______________________________ Dated _______________

Name ______________________