St Agnes Surgery

NEW PATIENT REGISTRATION - Please return completed form to Reception

Surname: ______________________________ **Date of Birth:** _ _ / _ _ / _ _ _ _

First Name(s): __________________________ **Preferred Name:** ________________________

Title: Mr ☐ Mast ☐ Mrs ☐ Ms ☐ Miss ☐ other:__________ **Gender:** __________ (please specify)

Street Address: ______________________________________ **(Home):** ____________________

Suburb & Postcode: ___________________________________ **(Work):** ____________________

Email: ____ **(Mobile):** ____________________

For future reference, please indicate if you are happy to receive SMS reminders:

Yes ☐ No ☐

Medicare Card: _ _ _ _ _ _ _ _ _ _ _ Ref No: _ Expiry date: _ _ / _ _

Pension Card: ____________________________ Expiry date: _ _ / _ _

Health Care Card: ____________________________ Expiry date: _ _ / _ _

Repatriation Card: ____________________________ Expiry date: _ _ / _ _ White ☐ Gold ☐

Next of Kin—please provide two contacts

Name: __________________________________ **Relationship to patient:** ____________________

(Home): _______________ **(Work):** _______________ **(Mobile):** ____________________

2nd Emergency Contact

Name: __________________________________ **Relationship to patient:** ____________________

(Home): _______________ **(Work):** _______________ **(Mobile):** ____________________

Patient chooses not to provide a second contact: ______________________________________ (sign)

Ethnicity: Aboriginal ☐ Asian ☐ Australian ☐ British ☐ Greek ☐ Indian ☐ Italian ☐

Torres Strait Islander ☐ Not listed ☐ (please specify): ______________________

Do you identify as: Aboriginal ☐ Torres Strait Islander ☐

Has any member of your immediate family consulted a Doctor at St Agnes Surgery or Tea Tree Surgery:

Yes ☐ No ☐ Uncertain ☐

How did you find us? Yellow Pages/ White Pages ☐ Webpage ☐ Friend/ Family ☐

Not listed ☐ (please specify): ______________________