TOTALCARE MEDICAL CENTRE PATIENT REGISTRATION FORM

TITLE:	FIRST NAME:	SURNAME:	PREFERED NAME:	DATE OF BIRTH:	SEX: Circle Male Female

Status:	Medicare number:	Reference Number	Expiry date:

Pension/Healthcare Card:		DVA number:

Regular Practitioner:	Name if different from Medicare card:

Alias Surname:	Name if Different from Medicare Card:	Health Insurance

ADDRESS Street:	Suburb:	Mob:	Home Ph:

Ethnicity:	Country of birth:	Occupation:	Work Ph:

Emergency contact name:	Emergency contact number:	Relationship:	Email:

Height in CM if known:	Weight in KGS if known:	Are you an Aboriginal or Torres Strait Islander/ATSI? YES/NO

Last pneumococcal: _____ Not sure/never	Last Influenza _____ Not sure/never	List of drugs you are taking:

DO YOU SMOKE: Yes/No How many a day ___	DO YOU DRINK Yes/No How many a week _____	History of anaphylaxis Yes/No	Allergies Yes/No List:

Do you give consent for our clinic to contact you via SMS : YES / NO, EMAIL: YES/NO

PRIVACY AGREEMENT: I understand that Totalcare Medical Centre complies with privacy Act (1998) and as part of their privacy policy they are committed in protection the privacy of individuals and their personal information. My signature below indicated that I have read the above consent Totalcare Medical Centre collecting using, storing and disposing of my personal information; the release of relevant personal information to other health professional to allow quality medical care I, inclusion in a recall register to be advised of following up visits, medical updates and health information,, inclusion in national/state reminder systems/ register the release of information to my (prospective) employer, their authorised representative and their insurer in the case of work related consultation or service understand I may withdraw my consent for Totalcare Medical Centre to use disclose my personal information (except when legal obligation must be met)

Name: _____ Signature of Parent/Guardian: _____Date:_____