Matraville Medical Complex

Patient Registration & Update Form

TITLE:	***FIRST NAME:***	***SURNAME:***	***KNOWN AS:***
DATE OF BIRTH: _ _ / _ _ / _ _ _ _	***SEX:***	***ARE YOU ABORIGINAL OR TORRES STRAIT ISLANDER?*** (Ask about our 'Closing the Gap') ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither	

ADDRESS:

STREET	
TOWN/SUBURB	
STATE:	POSTCODE:

CONTACT DETAILS:

TELEPHONE:	MOBILE:
EMAIL:	

MEDICARE INFORMATION: *EXPIRY DATE:*

______________ ___ ___/______

1234 56789 0
1 JOHN SMITH
2 HELEN SMITH
3 JAMES SMITH
4 JESSICA SMITH
VALID TO 11/10

ALLERGIES:

- ☐ Nil Known
- ☐ Yes (Please Specify):

____
____
____

EMERGENCY CONTACT/NEXT OF KIN:

FIRST NAME:	SURNAME:
TELEPHONE:	RELATIONSHIP:

ALCOHOL STATUS:

- ☐ Non-Drinker
- ☐ Occasional
- ☐ Moderate
- ☐ Heavy

SMOKING STATUS:

- ☐ Non-Smoker
- ☐ Ex-Smoker: Light/Moderate/Heavy
- ☐ Smoker: _________/day

ETHNICITY: ______________________________
OCCUPATION: ______________________________
ELITE ATHLETE: ☐ **YES** ☐ **NO**

☐ **PENSION** ☐ **HEALTHCARE CARD**
No: ______________________________
EXPIRY DATE: ______________________

DVA No: ______________________
Colour: ______________________

I do hereby consent for my medical information and test results to be sent to another doctor, specialist, solicitor or insurance company. If requested, I consent for staff at Matraville Medical Complex to request and receive medical information and test results (if applicable) on my behalf. I also consent to receiving SMS and/or email reminders from Matraville Medical Complex.

SIGNATURE: (Parent/Guardian): ______________________________ ***DATE:*** ______________________

If you would like more information on the services we provide, please ask reception for a copy of our latest newsletter.
Our privacy policy is on display on our website. If you would like a copy please ask reception.

August 2014