MANDURAH MEDICAL CENTRE

New Patient Registration Form

Title: Mr / Mrs / Ms / Miss / Mast

Surname: _____ Given Name(s): _____

DOB: _____ /_____ /_____ Marital Status: _____

Address: _____

Suburb: _____ State:_____ Postcode: _____

Telephone: (H) _____ (M)_____

Email Address: _____

If Under 18 yrs Parent/Carer/Guardian: Full Name _____

☐ **Is the patient/child subject of Family Court Orders.** ☐ **Is the patient/child under Dept Child Protection.**

☐ **I consent to receiving future SMS/ Email notifications (regarding recalls, results, appointment Reminders, etc) from this Practice.**

☐ **I consent for my health summary to be uploaded to PECHR (my health record)**

(Medicare & Concession Cards must be sighted by one of our staff members please)

Medicare Number: _____ Ref:_____ Expiry:_____

HCC ☐ **Pension Card** ☐ **Number: _____ Expiry:_____**

DVA Card Colour:_____ Number: _____ Expiry: _____

Allergies? _____

Are you:- Aboriginal ☐ **Torres Strait Islander** ☐ **Other Cultural Background _____**

Next Of Kin Name: _____ Relationship: _____ (P):_____

Emergency Contact Name: ***(must be different from above)*** **_____**

Relationship: _____ (P):_____

Cancellation of appointments:-

1. **Always call to cancel your appointments if you cannot attend.**
2. **A Non Attendance Fee applies for failure to cancel a booked appointment**
3. **Unpaid NAF (non-attendance fee) may mean you are refused an appointment until paid**
4. **I am aware my details can be passed on for the purpose of debt collection to our debt collectors**

Signature: _____ Date: _____

Your personal information is collected for the purposes of maintaining your medical record and/or contacting you on matters relating to your health. A full copy of our Privacy Policy is available from Reception.

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