East Corrimal Medical Centre

A: 17-19 Murray Road, East Corrimal NSW 2518
P: 02 4284 4677 | F: 02 4283 1785

PATIENT REGISTRATION FORM

Section A: Personal Details

Title	Surname	Given names	
Date of birth *(dd/mm/yy)*	**Gender**	**Marital status**	
Medicare card number	**Medicare reference number**	**Medicare expiry date**	
Pension, Health Care Card, or Veterans Affairs number (if applicable)		**Type of Card/Colour**	**Expiry date**

Occupation

Home address **Postcode**

Postal address **Postcode**

Telephone number	Work number	Mobile number

Email

Next of kin

Name	Relationship to you

Telephone number	Work number	Mobile number

Who can we contact in an emergency?

Name	Relationship to you

Telephone number	Work number	Mobile number

Minors *(under 16yo)*

Parent name	Mobile number	Address
Parent name	**Mobile number**	**Address**

Court ordered restrictions on either party *(please provide details)*

Section B: Cultural Backgrounds

Knowing your cultural background can help us provide healthcare that meets your individual needs.
Are you Aboriginal or Torres Strait Islander origin?

No ☐ **Yes, Aboriginal** ☐ **Yes, Torres Strait Islander** ☐ **Yes, both Aboriginal and Torres Strait Islander** ☐

Other cultural background (eg Mediterranean, Asian, African)	**Country of birth**

Is English your first language?		**If not, do you require an interpreter?**		**Please specify language**
Yes ☐	No ☐	Yes ☐	No ☐	

Section C: Allergies and medicines

List allergies and intolerances to medication	**Describe your reaction**

List regular medications and doses, and complementary medicines and doses

Section D: Consent

Our practice uses a reminder system to help you maintain your health. The practice sends reminders via SMS and telephone for appointments, and procedures such as vaccinations.	**I consent to being contacted with reminders to help me maintain my health**	Yes ☐ No ☐
Our practice sends information to the Australian Childhood Immunisation Register and Pap Smear Register. These registers also send reminders.	**I consent to being contacted with reminders the help me maintain my health**	Yes ☐ No ☐
Our practice securely sends information such as referrals to a Third party e.g. specialist, hospital.	**I consent to sharing my information for specialist and emergency care.**	Yes ☐ No ☐

Signature of patient or guardian	**Date**
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Section E: Transfer of health information

You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future healthcare needs. You may wish to have a copy, or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place. You can find our practice policy at www.ecmc.net.au

Please advise us if your contact information or Medicare details change.