Office use only

Scanned By:

Date:

DALE MEDICAL CENTRE

Patient Registration Form

629 Ranford Road
Forrestdale WA 6112
P: 08 61184570, F: 08 61184571
Email info@dalemedicalcentre.com.au
Web: www.dalemedicalcentre.com.au
ABN 12364976224

Surname:	Given Names:	Gender □M □F	Date of Birth:

Street Address:	Suburb	Postcode:	State:

Home Phone:	Mobile: Consent to SMS reminders □Yes □ No	Work Phone:

Email:

Occupation: Employer:	Are you an Aboriginal or Torres Strait Islander? Yes □ No □ Your Ethnicity : _____

Medicare No :	Ref No :	Valid To:
		/

Do you have Veteran Affairs File No? If yes Provide Type: □Gold □Orange □White

Do you have any other Australian Government Concession Card? Please provide details
Type: Number : Valid to:

Do have any Private Health Insurance? Please provide details
Name of the Insurer: Member No: Valid to:

Emergency Contact:
Name: Relationship: Contact No:

Next of Kin:
Name: Relationship: Contact No:

Do you smoke? □Yes □No If yes ___ Cigarettes per day	Alcohol Consumption: _____ Glasses per week

ALLERGIES If no Allergies Please tick □ Substance Reaction	**CURRENT MEDICATION** If no medication please tick □ Medication Dose Frequency	**FAMILY HISTORY** Any history of Cancers, Diabetes, Heart diseases etc. Relationship Condition

In accordance with the *Privacy Act (1988),* all information collected in this practice is treated as "sensitive information". To protect your privacy, this practice operates in accordance with the Act.
We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone number etc.
Selected information may be disclosed to various other health services involved in supporting your health care management, (e.g. Pathology & Radiology)
Please Note – Due to privacy laws it is preferred that adults and over sixteens arrange their own appointments whenever possible. Results **cannot** be given to a third party except under special circumstances.

CONSENT

☐ I consent to the use of my personal health information by Dale Medical Centre and other health providers involved in my medical treatment and health care.

☐ I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment.

Signature: - ……. Date: - …….. /…….. /……..