# New patient registration

Please complete this form before your first appointment. Your information is kept confidential.

## PERSONAL DETAILS

**Title**
☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mx ☐ Dr

**Given name**
_____

**Family name**
_____

**Gender**
☐ Female ☐ Male ☐ Prefer not to say

**Occupation**
_____

**Pronouns**
☐ She / her ☐ He / him ☐ They / them ☐ She / they ☐ He / they
☐ Any pronouns

**Are you of Aboriginal or Torres Strait Islander origin?**
☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander
☐ Neither Aboriginal nor Torres Strait Islander ☐ Prefer not to say

## CONTACT DETAILS

**Email address**
_____

**Mobile phone**
_____

**Home phone**
_____

## RESIDENTIAL ADDRESS

**Street address**
_____

**Suburb**
_____

**Postcode**
☐☐☐☐

**State**
☐ ACT ☐ NSW ☐ NT ☐ QLD ☐ SA ☐ TAS ☐ VIC ☐ WA

## MEDICARE

**Medicare number**
☐☐☐☐☐☐☐☐☐☐

**Individual reference number (IRN)**
☐

**Valid to**
☐☐ / ☐☐☐☐

## DVA CARD

Card colour ☐ Gold ☐ White ☐ Orange

Card number _____

Valid to ☐☐ / ☐☐ / ☐☐☐☐

## CONCESSION CARD

Card type ☐ Pensioner Concession Card ☐ Health Care Card

Customer reference number (CRN) _____

Valid to ☐☐ / ☐☐ / ☐☐☐☐

## PRIVATE HEALTH INSURANCE

Health fund _____

Member number _____

Member reference number _____

Valid to ☐☐ / ☐☐☐☐

## EMERGENCY CONTACT

Name _____

Relationship _____

Phone _____