The Grange Family Medical Centre

Patient information form

Mr, Mrs, Miss, Ms, Mast (Please Circle) DOB____/____/____ Sex: Male Female

Surname: ________________________ First Name: _______________

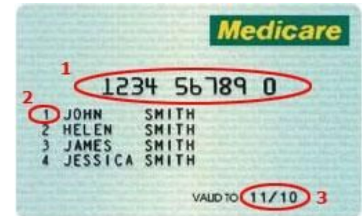
Address: ____

Home Phone:____________________ Work Phone: ______________________

Mobile:______________________ Email Address: _______________________

Medicare Details (1) Number: __ __ __ __ __ __ __ __ __ __ __

(2) Position on card:____ (3) Exp:________



Concession Card No: __ __ __ __ __ __ __ __ __ __ Exp: _________

Health Care Card or Pension Card (please circle).

DVA Card Number: __ __ __ __ __ __ __ __ GOLD WHITE OTHER

Occupation: __________________________ Marital Status: ______________

Ethnicity: ___________________

To assist with health initiatives, do you identify as?: ABORIGINAL TSI OTHER CULTURE (please circle)

Have you registered for a "My Health Record" ? YES NO

Next of KIN

Name: ______________________ Ph No: ____________________ Relationship: _______________

Please provide the name of a contact person you give us permission to call in an emergency and regarding recalls or appointment changes. (Or as above)

Name: ______________________ Ph No: ____________________ Relationship: _______________

Our practice provides patients with preventative health care & early case detection reminders either directly or through state/national registers eg. Annual health checks, immunisations, pap smears, health information sessions, clinics.

Do you wish to have relevant reminders? YES NO

Signature: _________________________________ Date___/___/___