REALCARE HEALTH CLINIC

245 Park St South Melbourne VIC 3205
Ph: 03 9699 1088 Fax: 03 96991699

NEW PATIENT REGISTRATION FORM

Mr Mrs Miss Ms Master

First Name: Surname: D.O.B. / /

Preferred Name / Known as:

Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐ Position on Card: ☐ Expiry Date: ____ / _____

Concession Card Number: ☐☐☐ ☐☐☐ ☐☐☐ ☐ Exp Date: ____/____/____ Pension: ___ HCC ___

DVA File No: (if applicable) N__ ☐☐☐☐☐☐ White ____ or Gold ____

IHI Individual Health Identifier: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Street Address:

Town: **Post Code:**

Home Phone: ( ) **Work Phone: ( )**

Mobile Phone:

Marital Status: **Occupation:**

Allergies:

Next of Kin:	Relationship:	Ph:
Emergency Contact:	Relationship:	Ph:

To assist with health initiatives, do you identify yourself as: (please specify)

ABORIGINAL OR OTHER CULTURE _____

Our practice provides patients with preventative health care *reminders* e.g. annual health checks, immunisations, pap smears, health information sessions & clinics. These will be sent to you automatically.
If you ***DO NOT*** wish to have this option, please inform our Reception Staff

Privacy in our Medical Practice

It is the policy of this practice to maintain the security of personal health information at all times and to ensure that this information is only available to authorised members of staff. Patient information may have to be disclosed to other doctors, nurses and medical technicians so that proper health care is not compromised. You can assist in maintaining the accuracy of your information by advising the practice of changes to your personal contact details.

I have read and understand the privacy information

Signature: Date: / /