Waterhall Medical Centre

TITLE: Mr Mrs Miss Ms Mst Other (please specify): _____

Gender Identity (Circle one): Male/Female/Transgender/Non-Binary/Gender Diverse/Different Identity

First Name (as shown on Medicare Card): _____

Surname (as shown on Medicare Card): _____

Date of Birth: _____

Address: _____

Suburb: _____ Post Code: _____

Home Phone: _____ Mobile: _____ Work: _____

Email Address: _____

Preferred method of contact (Circle One): Email / SMS
(NB: Recalls and reminders are sent by SMS only)

Occupation: _____

****PLEASE COMPLETE – ENSURES YOU RECEIVE CARE SPECIFIC TO YOUR ETHNICITY NEEDS**
Are you of Aboriginal or Torres Strait Island Descent (Circle One): Yes / No
If so, are you registered with Closing The Gap? Yes / No

Do you require a translator? (Circle One): Yes / No

What is your cultural background? _____
Please put COUNTRY of descent rather than region (ie China, Japan rather than Asia)

Medicare No: __ __ __ __ __ __ __ __ __ __ Position no: ____ Expiry Date: _____

Healthcare/Pension Card No (Please circle): _____ Expiry Date: _____

DVA Card No: _____ Colour: _____ Condition/s Covered_____

Private Health Fund Name: _____ Number: _____

Tick this box if you do NOT want your records uploaded to My Health Record ☐
(uploads include allergies, medications, immunisations & medical condition ONLY. Uploads DO NOT INCLUDE doctor's notes) This information is important for hospital and emergency situations.

Next of Kin: _____ Contact No:_____

Relationship: _____

Emergency Contact: _____ Contact No: _____

Relationship: _____

IT IS THE PATIENT'S RESPONSIBILITY TO FOLLOW UP ON RESULTS