Stratford Medical Centre

NEW PATIENT REGISTRATION FORM

Please assist us by completing the following

Surname	**Mr Master** **Mrs Ms Miss**		
First Name			
Date of Birth			
Street Address			
Suburb		**Post Code**	
Postal Address			
Suburb		**Post Code**	
Home Phone		**Work Phone**	
Mobile Phone			
Email Address			
Occupation			
Medicare Number		**Expiry Date**	**Position on card**
DVA Gold / White		**Expiry Date**	
Pension Card or Health Care Card		**Expiry Date**	
Nationality			
Ethnicity (Please circle)	Aboriginal Torres Strait Islander Both Aboriginal & Torres Strait Islander		
Next of Kin	**Name**	**Relationship**	
	Phone number		
Emergency Contact	**Name**	**Relationship**	
	Phone number		

Privacy

Your medical record is a confidential document. 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. Please refer to our Privacy Policy located at Reception or via our website.

Do you consent to the Doctors at Stratford Medical Centre uploading and accessing your My Health Record?

☐ **Yes** ☐ **No**

Do you wish to have SMS reminders sent to you?

☐ **Yes** ☐ **No**

Signature: _____ **Date:** _____