Main Street Medical Centre, Merimbula
Patient Registration Form

Please complete ALL of the following details

Title_____ First Name_____ Surname _____

Preferred Name_____ Gender_____

Date of Birth ____/____/_____

Are you (please circle) Aboriginal YES / NO Torres Straight Islander YES / NO

Other Nationality (please specify) _____

Home address_____ Postcode_____

Home phone number_____Work number_____

Mobile_____Do you consent to SMS Text Messaging YES / NO

Postal address_____ Postcode_____

Occupation (or previous occupation)_____

Are you (please circle) Married Single Divorced Widowed De Facto Separated

Next of kin name_____ Contact number_____

Relationship to patient_____

Emergency contact name_____Contact number_____

Relationship to patient_____

Please note that your account for treatment is to be paid immediately upon completion of your consultation with the doctor. Please sign below to acknowledge that you understand and accept this condition of service.

Signature_____ Date_____

Medicare Card ___ ___ ___ ___ / ___ ___ ___ ___ ___ / ___ Expiry ___ / _____

Line number _____ (number next to your name on your Medicare card)

Healthcare Card_____ Expiry _____ / _____ / _____

Pensioner Concession Card_____ Expiry _____ / _____ / _____

Veterans Card (Gold)_____Expiry _____ / _____ / _____

Veterans Card (White)_____ Expiry _____ / _____ / _____

How did you hear about our practice? (please circle)

Pharmacy Search Engine Social Media Our web page Newspaper

Other_____

Please hand this form into reception staff with your Medicare card and any concession cards you may have.