THE UNIVERSITY OF MELBOURNE

# The University of Melbourne Shepparton Medical Centre

## PATIENT REGISTRATION RECORD:

This registration form is used for several purposes. It comprises information necessary:

- to register you as a patient
- to form the basis of your medical record for Shepparton Medical Centre health care providers
- to allow us to contact you if needed

***Information provided on this form is treated as strictly confidential and will not be provided to any person or entity without your permission. Similarly, it will only be used by us for the purposes listed above. Please review our practice brochure and privacy policy for more detailed information in regards to our privacy obligations.***

Are you:
❒ Permanently transferring to the clinic?
❒ Temporary Patient (returning to your own clinic)
❒ Visitor to Shepparton. If so please advise Reception if you would like a copy of appointment sent to your GP

| **Title** | Ms Miss Mrs Mr Mstr Dr Prof Other? | | |
|---|---|---|---|
| **Surname** | | **Middle Name** | |
| **First Name** | | **Preferred Name** | |
| **Date of Birth** | | **Sex:** | Male ❒ Female ❒ |
| **Address Line 1** | | | |
| **Address Line 2** | | | |
| **Suburb** | | **Postcode** | |
| **Home Phone no:** | | **Mobile no:** | |
| **Occupation** | | **Work Phone no:** | |
| **Email address:** | | | |

| | |
|---|---|
| **Next of Kin** (name and telephone number) | |
| **Emergency Contact** (name and telephone number of the person we contact if needed.) | |
| **Head of Family** (If registering a child include parent/guardian name and contact details) | |
| **Country of birth:** | |
| **Do you speak a language other than English at home?** | ❒ No, English only.<br>❒ Yes, please specify. |
| **Are you of Aboriginal or Torres Strait Islander origin?** | ❒ – Aboriginal<br>❒ – Torres Strait Islander<br>❒ – Aboriginal & Torres Strait Islander |

*Please Turn Over*

| Medicare Number and Ref | # | Line No: | Expiry Date: | |
|---|---|---|---|---|
| Pension No: | # | | Expiry Date: | |
| Health Care Card No: | # | | Expiry Date: | |
| DVA: Gold ❒ White ❒ | # | | Expiry Date: | |
| Private Health Cover | Name: | | # | |

Reminder System:

- Our practice provides patients with preventative care and early case detection reminders.
  I do not wish to receive these reminders. ❒
- Do you wish to receive a reminder of your appointment via SMS on your mobile: Yes ❒

**Are you willing to have a medical/health student in attendance at your consultations? YES ❒ NO ❒**

**Authorised Person:** I authorise the following person to act on my behalf in regards to access to my records, results and other information that may be held by the clinic.

Authorised Person :____________________ Relationship to you: ____________________

Contact Details: Ph: ____________________ Email: ____________________

I have read the Privacy Policy and agree for correspondence to be sent to other clinicians involved in my care. I undertake to pay all fees owed to Shepparton Medical Centre.

**Signed: ____________________ (Self or Guardian) Date: ____________________**