KEILOR VILLAGE MEDICAL

767 Old Calder Hwy, Keilor Vic 3036 Phone: 03 9331 6967 Fax: 03 9331 5232

PATIENT REGISTRATION FORM

TITLE:	MR MRS MISS MS OTHER	**GENDER:** MALE FEMALE
SURNAME/FAMILY NAME:		
PREFERRED NAME:		
DATE OF BIRTH:	/ /	**Are you Aboriginal or Torres St Islander** YES / No

ADDRESS:	
SUBURB:	
POSTCODE:	

CONTACT DETAILS: please indicate preferred contact number.

HOME PH:	
MOBILE PH:	
WORK PH:	
EMAIL	
	DO YOU WISH TO RECEIVE SMS MESSAGES PLEASE CIRCLE YES / NO

POSTAL ADDRESS: Only if different to the HOME address above.		**Is English your main language?**
SUBURB:		**Yes / No**
POSTCODE:		**If No, what is your main language?** _____

MEDICARE NUMBER (ten digit number)	**Ref No.**	**EXPIRE DATE:**	
VETERAN AFFAIRS		**EXPIRE DATE:**	
HEALTH CARE CARD		**EXPIRE DATE:**	
PENSION CARD		**EXPIRE DATE:**	

NEXT OF KIN DETAILS:

SURNAME		**HOME PH:**	
GIVEN NAME		**MOBILE PH:**	
RELATIONSHIP		**WORK PH:**	

EMERGENCY CONTACT:

NAME		PHONE	

Have you registered your EFT/Bank details with Medicare? Yes/No

We routinely offer a recall/reminder service for Your Health & Wellbeing (e.g.: skin checks, annual health reviews, pap smears, cholesterol check etc.) Please advise our staff if you do NOT wish to participate.

Is this consultation part of a Worker's Compensation and/or Motor vehicle accident claim? Yes/No

If yes please provide Insurer and Claim Number.

Insurer:_____

Claim NO: _____

Please Note: Until such time as we have an authorised claim number or acceptance from your insurer, you will be responsible for any fees incurred. Once your claim is accepted, your insurer will reimburse costs and all subsequent accounts relating to your claim will be forwarded to your insurer.

Do you have Private Health Insurance Yes / No

If Yes Fund Name: _____

Membership Number: _____

Do you have another GP outside of this practice that you visit?

If Yes: Drs Name: _____

Address: _____

_____

Phone No: _____

Do you have any Allergies? Yes / No

If Yes please provide details:

Do you or have you ever smoked?

Current smoker: _____

Previous smoker: _____

Never smoked: _____

If you are a New Patient to the practice, can you please let us know how you came to hear about Keilor Village Medical:

Family Member **Friend** **Website** **Health Engine** **Other:**

Patient Signature: _____ **Date:** ___/___/_____

Thank you for providing the information on this form. All information on this form is treated confidentially and in accordance with Privacy Regulations.