Boronia Medical Centre
Patient Registration Form

Patient Surname: ____________________ **Name:** ____________________ **Title:** __________

Address: ____

Suburb: ____ **Postcode:** __________

Date of Birth: ____/____/____ **Email:** ________________________________

Home Ph.: ______________ **Work Ph.:** ______________ **Mobile Ph.:** ______________

Parent/Guardian Name (If Under 16): ________________________________

Address: ________________________________ **Date of Birth:** ____/____/____

Emergency Contact Name: ____________________ **Relationship:** ______________

Emergency Contact Number: ________________________________

☐ **Tick to confirm that your Next of Kin is the same as your Emergency Contact**

Next of Kin Name (If Different) : ____________________ **Relationship:** ______________

Next of Kin Contact Number: ________________________________

Medicare Number: ____________________ **Ref No:** ______ **Expiry:** ______________

HCC No / Senior HCC: ______________ **Grant Date:** __________ **Expiry:** ______________

Pension Card No: ______________ **Grant Date:** __________ **Expiry:** ______________

DVA Card No: ____________________ **White/Gold:** ______ **Expiry:** ______________

Country of Birth: ____________________ **Cultural Background:** ____________________

Are you of Aboriginal or Torres Strait Islander origin?
Aboriginal ☐ Torres Strait Islander ☐ Both ☐ None ☐ Not Stated ☐

Is this visit related to a work cover claim or transport accident claim?
Work Cover ☐ Transport Accident ☐ None ☐ Claim No:

Our practice undertakes research, professional development and quality assurance/improvement activities to improve patient care. All people accessing health information for this purpose have signed a written confidentiality agreement. I consent to my records being reviewed as a part of the quality improvement activities at this practice:
YES ☐ NO ☐

Our practice uses a reminder system to improve the quality of your healthcare. The practice sends reminders by mail for procedures such as vaccinations, pap tests and other health reviews. I consent to being contacted with reminders:
YES ☐ NO ☐

Our practice operates a Chronic Disease Register, is your health affected by any of the following?
Diabetes ☐ Asthma ☐ High Blood Pressure ☐ High Cholesterol ☐ None ☐

I consent to being placed on such a register if required:

YES ☐ NO ☐

Please discuss current medications with your doctor, as well as any allergies or intolerances.

Signature of Patient or Guardian: ________________________________ **Date:** ____/____/____

Boronia Medical Centre
Patient Registration Form