NEW PATIENT REGISTRATION FORM

Given Name _____Surname _____

Known as_____Date of Birth _____/___/_____Gender_____

Are you Aboriginal and/or Torres Strait Islander? YES / NO

Country of birth _____

Are you currently an Australian Citizen? YES / NO

Is there any cultural background we should be aware of? YES / NO

If so, please specify_____

Residential Address _____

Suburb & State _____Postcode _____

Postal Address (*if different to above*) _____

Phone (M) _____ (W) _____ (H) _____

Regular GP _____Practice _____

Please complete a transfer of medical records form at reception

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Please indicate if you would like to receive SMS services (Including but not limited to; appointment reminders, recall alerts, reminders and other services)
*Please note you may opt-out at any time by notifying the practice.

☐ YES, I would like to receive SMS services
☐ NO, I would like to opt-out of receiving SMS services

Medicare Number_____

Reference Number_____Expiry date (MM/YY) _____/_____

Commonwealth Concession Card Type Pension / Health Care / Seniors

Entitlement Number _____ Expiry Date _____/_____

Veterans Affairs Card Type Gold / White / Orange

DVA Entitlement Number _____ Expiry Date _____/_____

Next of Kin / Emergency Contact

Given Name _____Surname _____

Mobile / Work / Home _____ Relationship_____

Campbell Medical Practice is fully compliant with all Commonwealth and Territory Privacy Legislation requirements.
To obtain a copy of our privacy policy, please ask at reception or, alternatively, it is available on our website.