Triple C Health - Registration form

Title Mr/Mrs/Miss/Ms/Dr/Mast DOB: __/__/____

Surname: Given name(s):

Address:

Suburb: Post Code:

Aboriginal Origin Yes / No Torres Strait Islander Origin Yes / No

Ethnicity: ________________

NB* *People of Aboriginal and/ or Torres Strait Islander origin are generally eligible for additional benefits under the "Closing the Gap program"*. Ask your Doctor or Nurse to find more.

Contact Numbers Home: ______________ Work: ______________

Mobile: ______________ Email: ____________________

Medicare Card number: (above) Ref no: ____ Expiry: __/____

Pension/HCC/DVA (please circle one)	Concession Card Numbers	Expiry date DD/ MM /YYYY

ALLERGIES and Reactions (Please Specify):

Private Health Insurance Fund Name: ______________ Policy No: ______________

Next of kin contact	Name :	Relationship:
	Home:	Mob:
Emergency contact	Name:	Relationship:
	Home:	Mob:

What is your Occupation?

Do you require a Translator? Yes / No (Ph:131 450) Language:

Patient Consent

This practice has a policy of **clinical handover to another practitioner within the clinic** when you want to consult other doctor or your usual treating doctor is not available in order to manage follow up care. To give you the best possible care, your information may also be given to Specialists, Radiology, Pathology and Allied Health Services providers etc. that you are referred to.

I **consent** to the information provided above to be used to contact me (including through **email and text messaging and recording voice message on my home or mobile phone**) and that my personal health information may be used for statistical purposes.

I have read and understood the above policy.

Patient / Parent / Guardian signature: ____________________ Date: __/__/____

How did you find us? Through: family & friends/ website / internet search/ flyer etc./ found while shopping / advertisement / Fridge magnet/ other (please mention)