South Kempsey
Medical Centre

Patient Registration Form

Please complete and send this form in person / mail : 44 Lachlan Street South Kempsey 2440 or fax: 02 7228 5892

Information provided on this form is treated strictly confidential and will not be provided to any person or entity without your permission. Our Privacy policy is available at the Practice.

Title (please circle)	Ms Miss Mrs Mr Mast Dr Prof Other	Medicare Card No.	
Surname		Medicare Line No.	
First Name		Medicare Expiry Date	
Middle Name		Pensioner Concession / Health Care Card / Seniors Health Card	No.:
Preferred Name			Expiry Date:
Date of Birth DD/MM/YYYY		Card Type (please circle)	Health Care Card Seniors Health Card Pensioner Concession
Gender	Male Female Non-Binary	DVA Card No. and colour	Gold White
Ethnicity / Nationality			
Do you wish to be recognised as an:	Aboriginal	Torres Strait Islander	Neither (please circle)
Home Address		Postal Address (if different)	
Home Phone		Email	
Mobile		Religion (optional)	
Work Phone		Current Occupation	

Emergency Contact (who we can ring in case of an emergency):

Name : _____

Phone number: _____

Relationship to you: _____

Next of Kin (Not Same as emergency contact)

Name: _____

Phone number: _____

Relationship to you: _____

Reminder System

South Kempsey Medical Centre GPs take a preventative approach to your health. You may receive reminder letters or be reminded at your next visit of ongoing follow-up for preventative care.

Privacy

In some circumstances, we will need to contact you to confirm specific appointments and matters regarding your health. Contact maybe on your answering machine, message bank, SMS message or by email.

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

How did you hear about us?

❑ Google ❑ Social Media ❑ Word of Mouth

❑ Other - Please specify: