PLEASE WRITE CLEARLY

MARGARET RIVER Medical Centre
Caring for you and your family

First Name: _____ Title: _____

Surname: _____

AS SHOWN ON YOUR MEDICARE CARD

Preferred Name: _____

Date of Birth: _____

Residential Address: _____

Postal Address: _____

Phone: (H) _____ (W) _____

Mobile Number: _____ Yes / No Happy to receive SMS messages/Reminders

Email Address: _____

Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐ Ref (next to name) ☐ Expiry Date /

Concession Card: ☐ Pension ☐ HCC ☐ DVA ☐ Commonwealth Seniors Card

Concession Number: _____ Expiry Date

Private Health fund ☐ Yes ☐ No

ATSI: ☐ Non Aboriginal ☐ TSI ☐ Aboriginal

Country of Birth: _____ Religion (not compulsory) _____

Occupation: _____ Place of Work: _____

Allergies: _____

Significant Family History: _____

Are you a smoker? ☐ Smoker ☐ ex-Smoker - Date ceased _____ ☐ Never Smoked

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Next of Kin Details

Name: _____

Relationship: _____

Address: _____

Contact Number: _____

Contact person in case of Emergency: (other than next of kin)

Name: _____

Relationship: _____

Address: _____

Contact Number: _____

I give my consent for the Margaret River Medical Centre to collect my personal health information to be used for my health and medical management.

Signed: …….. Date: ……