**Chipping Norton Medical Centre**

ABN 82491304711

Shop 15, 45 Barry Road Phone: (02) 9726-9300

Chipping Norton NSW 2170 Fax: (02) 9726 9322

Website: [www.chippingnortonmedicalcentre.com.au](http://www.chippingnortonmedicalcentre.com.au) **Douglas Pathology onsite**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Patient Registration Form**

**Please Circle:** Mr / Mrs / Ms/ Miss / Master **Date of Birth:** ........../............/............

**First Name:** ................................................ **Surname:**.................................................................

**Address:** ............................................................................................................................................................

**Suburb:** ............................................................. **State:** ……………………………. **Postcode:** …………………….

**Contact No:** (Home): ………………………… (Work): …………………… (Mobile)……………………………….

**MEDICARE NO**: ……………………………………… **CARD REF**:…………….. **EXPIRY**:……………/………………..

**Concession Cards:** Pension Centrelink Healthcare Card Veterans Affair

Card No: …………………………………………. Expiry Date: …………/……………/………………

**Please Circle:** Aboriginal Torres Strait Islander Aboriginal & Torres Strait Islander Non-Indigenous

**Martial Status: Occupation:** ………………………………….

☐Single

☐Married **Country of Birth:** ……………………………..

☐Defacto

☐Divorced **Ethnicity:** ………………………………………

☐Separated

☐Widowed

**Next of Kin/Emergency Contact: Full Name: ………………………… Contact Number: ………………………………**

**Relationship to you: …………………………………**

**Note:** By becoming a patient of this Practice, you are giving the Practice team informed consent to release your health information to other health professionals (ie: specialist, hospitals etc) for the purpose of management and continuity of care. Your information will be kept secure and confidential and will not be released to other third party (ie: insurance comp, lawyers or family member etc.) without your written consent. I also consent to receive recall/reminder by sms.

If you wish NOT to participate please tick this box ☐

**CONSENT TO BULK BILLED**

As we are a bulk billing practice, the Practice will NOT be printing Medicare Claim vouchers due to environmental reasons and therefore the patient gives the treating doctor informed permission to bulk-bill Medicare appropriately on their behalf.

If you do not wish for the doctors to claim Medicare on your behalf, please tick this box☐

Signature: ……………………………………………………………… Date:…………………………………………………..