For Office Use Only
Patient Number:
Date Completed:

PATIENT REGISTRATION FORM

REDFERN STATION MEDICAL CENTRE
ABN 47547095857

Level 1, 147-151 Refern stret
Redfern NSW 2016
P 8313 2999
F 8313 2990
E admin@redfernstationmc.com.au
W www.redferstationmc.com.au

PATIENT INFORMATION

Surname:	Given Names:	Date of Birth:
Street address:	Suburb: / State: / Postcode:	Gender: ❑ M ❑ F
Home Phone:	Employer:	Smoker: ☐ No ☐ Yes
Mobile:	Occupation	If Yes, _______ Cigarettes/day
Work Phone:	Are you an Aboriginal or Torres Strait Islander? please tick: ☐	Alcohol Consumption:
Email Address:		_______________ Glasses/week

EMERGENCY CONTACT

Name:	Relationship:	Contact No.:

MEDICARE/ CONCESSION CARDS/PRIVATE INSURANCE

SAMPLE ONLY Medicare
1234 56789 0
1 JOHN SMITH
2 HELEN SMITH
3 JAMES SMITH
4 JESSICA SMITH
VALID TO 11/10

Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐

Ref Number: ☐

Valid To: ☐☐ ☐☐ RHCA: ☐

Do you have a **Veteran Affairs File Number**? If yes, please provide ☐☐☐☐☐☐☐ Type: Gold ☐ Orange ☐ White ☐

Do you have any other **Australian Government/Concession Card**? (Student Concession excluded):

Type: Number: Valid To:

Do you have any **Private Health Insurance**? If yes, please provide detail:-

Insurance Name: Policy Number: Valid To:

MEDICAL INFORMATION

ALLERGIES: If NO allergies, please tick: ☐

Substance	Reaction

Medical History – Including Current:

Year	Condition / Operation

Family History: Any history of Cancers, Diabetes, Heart diseases, etc

Relation	Condition

CURRENT MEDICATION: If NO medication, please tick: ☐

Medication	Dose	Frequency

SIGNATURE

Sign Here: ____________________________________

CONFIDENTIAL

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