Warrumbungle Medical Centre

New Patient Registration Form – Adult (over 16)

Personal Details

Title:_____ First Name:_____ Middle Name:_____ Surname:_____

Preferred Name:_____ Date Of Birth: _____/_____/_____ Gender: M ☐ F ☐ Other ☐

Marital Status: ☐ Single ☐ Married ☐ De facto ☐ Separated ☐ Divorced ☐ Widowed

Medicare Card Number: __ __ __ __ __ __ __ __ __ __ Ref No: ___ Expiry Date: ____/____

Pension / Healthcare Card / Veteran Affairs Number:_____ Exp Date:___/___/____

Occupation:_____Employer:_____

Phone (Home):_____ (Work):_____ (Mobile):_____

Email Address:_____

Residential Address:_____

Suburb:_____ Postcode:_____

Postal Address (if different):_____

Preferred Contact Method: Email / Letter / Phone

Emergency Contact/Next of Kin

Name:_____ Relationship To You:_____

Phone (Home):_____ (Work)_____ (Mobile)_____

Cultural Background

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander Origin? No ☐ Aboriginal ☐ Torres Strait Islander ☐

Country of Birth:_____ What year did you move to Australia?_____

Is English your first language? ☐ Yes ☐ No

If no, please specify:_____ Do you require an interpreter? ☐ Yes ☐ No

Workers Compensation: Warrumbungle Medical Centre does not take on worker's compensation cases that have been initiated elsewhere or by other doctors. New patients worker's compensation matters in progress will not be attended to. I understand that as a new patient my existing worker's compensation claim will not be discussed during consultations at Warrumbungle Medical Centre ☐ Yes

www.warrumbunglemedicalcentre.com
59 Cassilis Street Coonabarabran 2357
Ph: (02) 68423333 **F:** (02) 68423330
front.desk.wmc@gmail.com

Brief Medical History

Medical History: (Chronic diseases/illnesses, operations etc.)

_____

_____

_____

_____

_____

_____

Regular Medicines and Doses: (Please include complementary medicines and doses)

_____

_____

_____

_____

_____

_____

Allergies/Intolerances: (Please state what to and describe your reaction)

_____

_____

Smoker Status: ☐ Never ☐ Ex Smoker ☐ Smoker

Consent
Our practice uses a reminder system to improve the quality of our healthcare. The practice sends reminders by mail or telephone for procedures such as vaccinations, pap smears and other health reviews. We also send appointment reminders via text message.

I consent to be contacted with reminders to help me maintain my health and appointments: ☐ Yes ☐ No

Non-attendance and Late Cancellation of Booked Appointments
Please allow a minimum of 2 hours notice for cancellation of booked appointments. Failure to cancel or attend a booked appointment will incur a fee and further appointments will not be made until the account is paid in full.
Standard fee: $80 Double appointment: $160

I understand that I will incur a fee for non-attendance or late cancellation of booked appointments: ☐ Yes

Signature of Patient / Guardian: _____ Date: _____

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