16 Harding Street Coburg 3058
P: 9384 1321 F: 9384 1431

2 Harding Street Coburg 3058
P: 9386 6000 F: 9386 7006

5 Harding Street Coburg 3058
P: 9384 1321 F: 9355 8081
Chronic Disease & Preventative Health Annex

Patient Registration Form

Title – please circle	Mr.	Mrs.	Ms.	Miss.	Master.	Dr.
Surname:			First Name:			
Date of Birth:			☐ Female		☐ Male	
Address:						
Email Address:						
Home Number:		Mobile Number:			Work Number:	
Do you agree to receive **NORMAL** results via SMS? ☐ Yes ☐ No						

Next of Kin	Surname:	First Name:	
Home Number:	Mobile Number:	Work Number:	
Relationship to you:			

Emergency Contact	As Above? ☐ Yes ☐ No		
If No Name:	Relationship to you:	Contact Number:	

Do you identify as:	Aboriginal?	☐ Yes	☐ No
	Torres Strait Islander?	☐ Yes	☐ No
	Aboriginal & Torres Strait Islander?	☐ Yes	☐ No

Medicare Card No:	Order on Card:	Expiry Date:
Pension Card No:		Expiry Date:

Medical History/Conditions – please list your medical history or conditions you have:

Allergies	☐ Yes	Please State:		☐ No
Smoking	Non Smoker	☐ Yes		
	Ex Smoker	☐ Yes	Year Ceased?	How many did you smoke per day?
	Current Smoker	☐ Yes	Year Started?	How many do you smoke per day?
Alcohol	☐ Yes	☐ No	If Yes how many per day/week?	

Operations - please list any operations you have had:

Have you been **in hospital** for any reason?	☐ Yes	Reason:	☐ No

Medication – please list including herbal medications or supplements

If your doctor thinks you need an **AMBULANCE** one will be called for you. If you are not covered then you will be liable for the cost. **JOIN AMBULANCE VICTORIA** to save yourself the worry. **Go to** www.ambulance.vic.gov.au

OFFICE USE ONLY:	Dr Name:	Date:	Staff Initials: