Patient Registration Form
Ashford Avenue Family Practice

Patient Details			
Title:	◯ Mr ◯ Mrs ◯Miss ◯ Ms ◯ Other:		
Surname:			
First Name:			
Middle Name:			
Date of Birth:			
Address:			
Postal Address: (if different)			
Home Phone:			
Work Phone:			
Mobile Phone:			
Occupation:			
Medicare Number:	Ref No:	Expiry Date	
Pension/Healthcare Card No: (If Applicable)		Expiry Date	
DVA Number: (If Applicable)		Expiry Date	

Next of Kin	Name:	Relationship:
	Telephone:	
	Address:	
Emergency Contact (if different to above)	Name:	Relationship
	Telephone:	
	Address:	

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

Are you of Aboriginal or Torres Strait Islander Origin?
◯ No
◯ Yes – Aboriginal ◯ Yes – Torres Strait Islander ◯ Yes – Aboriginal & Torres Strait Islander

Cultural Background: (e.g. Asian, African, Mediterrean)	
Country of Birth:	

Transfer of Health Information
You may have consistently consulted with a GP at another practice. The health information held by that GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

Please advise us if your contact information or Medicare details change.

Consent
Our practice uses a reminder system to improve the quality of your health care. The practice sends reminders by mail or telephone for procedures such as vaccinations, pap smears and other health reviews.

I consent to being contacted with reminders to help me maintain my health.
◯ Yes ◯ No

Signature of patient or guardian _____ Date ___ / ___/ ___