Armidale Medical Centre

PATIENT INFORMATION FORM

Title: ***(please circle)*** Mr Mrs Ms Miss Master Other ***(please specify)***:

Surname:	Given Names:
Date of Birth: / /	Preferred Name:

Gender ***(please circle)***: Male Female Other

To assist with health initiatives, please complete the following:

Cultural Background: Are you of Aboriginal or Torres Strait Islander Origin? Yes ☐ No ☐

If yes, please specify: Aboriginal ☐ Torres Strait Islander ☐

Other ***(please specify)***:

Home Address: City/Suburb: State: Postcode:	Postal Address ***(if different to home address)***: City/Suburb: State: Postcode:
Other contact details: Phone (H): Phone (W): Phone (mob): Personal email: **Consent to SMS reminders:** YES ☐ NO ☐ **Consent to email correspondence:** YES ☐ NO ☐	Medicare No: (10 digits): Ref No: (ID No) Exp: / Pension type: Pension No: Exp: / Private Health Cover: Yes ☐ No ☐ Fund Name: Member No

Head of Family (if patient is under 16 yrs):

Emergency Contact: Name: Phone: Relationship: Contact address: City/Suburb: State: Postcode:	**Next of Kin:** ***(If different to Emergency Contact)*** Name: Phone: Relationship: Contact address: City/Suburb: State: Postcode:

I agree to have preventive care and early detection reminders sent to me. **YES** ☐ **NO** ☐

Signature: **Date:**