MELBOURNE CITY MEDICAL CENTRE REGISTRATION FORM

Title(eg. Mr):_____First/Given Name:_____Family/Surname:_____

Date of Birth:_____/_____/_____ Male / Female Occupation:_____

Address:_____

Town/Suburb:_____ Postcode:_____

Tel No. Home:_____ Work:_____ Mobile:_____

Emergency Contact Name:_____ Emergency Tel No: _____

How did you know about our Medical Centre:_____

Medicare No.(10 digits/numbers):_____

Medicare Patient Ref. No. **(Number in front of your name)**:_____ Expiry Date **(bottom right of card)**:_____/_____

OSHC / BUPA Card Member No: _____ Expiry Date_____/_____/_____

Concessions: Health Care Card No: _____ Expiry Date:_____/_____/_____

(Centrelink) Pensioner Card No: _____ Expiry Date:_____/_____/_____

Veteran Card No: _____ Expiry Date:_____/_____/_____

Others: _____ Expiry Date:_____/_____/_____

Select if you would like to be identified by your cultural background: N/A / Aboriginal / Torres Straight Islander

Smoking History (eg. Yes, No, Heavy, Social):_____ Alcohol History:_____

Past Medical History: _____

(eg. asthma, _____

surgeries, etc.) _____

Current Medication: _____

_____

Allergies: _____

Family History: _____

(eg. bowel cancer _____

or breast cancer) _____

OPTIONAL:

1. When was the last time you had your blood pressure reviewed? _____
2. When was the last time you had your cholesterol checked? _____
3. When was your last Pap smear? (females only) _____