For Office Use Only
Patient Number:
Date Completed:

PATIENT REGISTRATION FORM

HYDE PARK MEDICAL CENTRE
ABN 35 339 948 132
175 Liverpool Street Sydney NSW 2000
P 9283 1234
F 9283 0303
E hpmc175@optusnet.com.au
W www.hydeparkmc.com.au

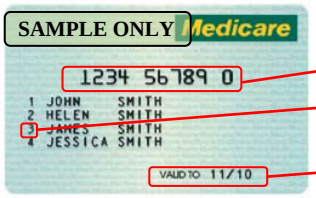
PATIENT INFORMATION

Surname:	Given Names:	Date of Birth:
Street address:	Suburb: / State: / Postcode:	Gender: ❑ M ❑ F
Mobile:	Home Phone:	Smoker: ☐ No ☐ Yes
Email:	Work Phone:	If Yes, _____ Cigarettes/day
Ethnicity: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Australian ☐ Others, please state: _____		Alcohol Consumption: _____ Glasses/week
Employer:	Occupation:	

EMERGENCY CONTACT

Name:	Relationship:	Contact No.:

MEDICARE/ CONCESSION CARDS/PRIVATE INSURANCE



Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐

Ref Number: ☐

Valid To: ☐☐ ☐☐ RHCA: ☐

Do you have a **Veteran Affairs File Number**? If yes, please provide ☐☐☐☐☐☐☐ Type: Gold ☐ Orange ☐ White ☐

Do you have any other **Australian Government/Concession Card**? (Student Concession excluded):

Type: Number: Valid To:

Do you have any **Private Health Insurance**? If yes, please provide detail:-

Insurance Name: Policy Number: Valid To:

MEDICAL INFORMATION

ALLERGIES: If NO allergies, please tick: ☐

Substance Reaction

Medical History – Including Current:

Year Condition / Operation

Family History: Any history of Cancers, Diabetes, Heart diseases, etc

Relation Condition

CURRENT MEDICATION: If NO medication, please tick: ☐

Medication	Dose	Frequency

SIGNATURE & DECLARATION

I hereby confirm that the information provided by me herein is true and correct, and that I have read and understood the Patient Information Sheet.

Sign Here: _____