Suite 2 & 3 Birubi Chambers
Hawker Place
Hawker ACT 2614
Tel : 02 62552400 Fax: 02 62551645
contact@hawkermedical.com.au

Patient Registration form

Title : _____ Family name:_____

First Name: _____ Preferred name: _____

Date of birth: _____ Country of Birth : _____

Language spoken at home: _____

Gender : ○ Male ○ Female ○ Other:_____

Are you Aboriginal or Torres Strait Islander? ○ Yes ○ No ○ Both ○ Neither

Address: _____

Suburb: _____ State:_____ Postcode: _____

Contact number: (M) _____ (H) _____

Email address: _____

Medicare Details

Medicare number: _____

Reference Number: _____ Expiry Date: _____

DVA card number: _____

Card type: ○ Gold ○ White Expiry date: _____

Government issued pension or health care card ○ Yes ○ No

CRN Number: _____ Expiry date: _____

Hawker Medical Practice

Emergency Contact

Emergency contact name: _____

Relationship: _____ *Contact number:*_____

Next of Kin: ○ *Same as above*

Name: _____ *Contact number:* _____

Relationship: _____

Consent

Hawker Medical Practice uses the information on this form to assist in managing & planning your medical & health problems. The collection, storage, and release of the information provided are protected under the Privacy Act 1988. HMP only gives this information to someone else where the patient gives permission or in special circumstances where Commonwealth legislation allows or requires it.

I consent to my nominated treating GP, GPs, and staff at HMP, other treating practitioners, and allied health providers exchanging all relevant information to maintain my health and medical problems. I understand this information will be used by doctors and staff at HMP to fulfill their functions as General Practitioners working in an accredited general practice for my healthcare planning and management of my medical conditions. I understand that I have the right to request my nominated treating GP NOT to release certain information, the details of which will be discussed in confidence with my nominated GP. I have received a copy of the HMP information & privacy policy.

Print Name : _____

Signature: _____ *Parent/ Guardian if child is under 16

Date: _____

Staff use: *ID Check:* ○ *DL* ○ *Medicare card* ○ *Other:* _____

Dr: _____

Staff Initial: _____