Red Hill Doctors Surgery Patient Detail Form

Title: Mr / Mrs /Ms / Miss / Mast / Dr (Please circle**)** **Language Spoken:.....**

Are you (please circle): Non-indigenous, Aboriginal, Torres Strait Island or Aboriginal**/**Torres Strait Island

First Name: _____ **Known as:** _____**Surname:** _____

Date of Birth:_____ **Sex:** (M/F) **Marital Status**: _____

Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐ **Ref Number:** ☐ **Expiry Date:** _____

Do you hold a Centrelink Health Care Card/ Pensioner Card / Gov Seniors Card? (Please circle)

Card Number: _____ **Expiry Date**: _____**Receive SMS appt reminders: Y N**

Address: _____ **Postcode:** _____
(residential)
Postal Address: _____ **Postcode**: _____

Phone Numbers: Hm: _____ Wk:_____ Mobile: _____

PREFERRED CONTACT NUMBER:_____ **E-mail:** _____

Next of Kin: _____ **Relationship to Patient**: _____
Phone Number: (h) _____ (w) _____ (mobile) _____

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<u>Preffered Payer:</u> (Only for children)_____
Medicare Number: _____
Address: _____ Post Code: _____

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