



# SYDNEY CBD MEDICAL CENTRE

## PATIENT DEMOGRAPHIC REGISTRATION FORM

<b>Surname:</b>	<b>First Name:</b>	<b>Date of Birth:</b> _ _ / _ _ / _ _ _ _
<b>Title:</b> <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other _____		<b>Gender:</b> Male / Female
<b>Medicare Number &amp; Reference No</b> (number in front of your name):	<b>#</b> <b>Ref:</b>	<b>Expiry:</b>
<b>Do you have a Centrelink Health Care Card / DVA Pensioners Concession etc?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>#</b> <b>Expiry:</b>
<b>Unit/Street Number/ Street Address</b>		
<b>Suburb and Post Code</b>		
<b>Home Phone</b>		
<b>Work Phone</b>		
<b>Mobile Phone</b>		
<b>Email</b>		
<b>Emergency Contact</b> (Name, Mobile number & relationship of the person we can contact if needed)		

**ALLERGY: Do you have any allergies to any medication?**

☐ Nil known ☐ Yes. Please elaborate:

**REMINDER SYSTEM**

Our practice provides our patients with preventive care and early case detection reminders e.g. Immunisations, Annual Health Checks, Skin Checks and Pap smears.

Please tick 'NO' if you do not wish to have any relevant health reminders sent to you... ☐ No

**Family History – Any significant family history of illness & cancer?**

☐ No ☐ Yes. Please elaborate on type of illness and side of family (Maternal/Paternal Grandparents etc):

**Occupation:**

**Alcohol** : ☐ No. ☐ Yes: \_\_\_\_ Days per week \_\_\_\_ Standard drinks per day

**Tobacco** : ☐ No. ☐ Yes: Cigarettes \_\_\_\_ per day **or** ☐ Ceased smoking

**Ethnic Background:****To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?**

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander

For each consultation, I assign my right to Medicare benefits to the doctors of Sydney CBD Medical Centre who will I am aware that this Practice has a Privacy Policy on handling patient information and is available to me on request. I understand it is necessary for this Practice to collect personal information from me for the purpose of health management and for associated administrative purposes. I understand that failure to provide this Practice with all the information it needs may restrict its ability to provide the quality of health care that I want.

I am aware of my rights to access my medical information from this Practice, which will be made available upon my request with adequate notification time.

I acknowledge that I have read and understood this form before signing it.

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_