For Office Use Only
Patient Number:
Date Completed:

HYDE PARK MEDICAL CENTRE
ABN 35 339 948 132
Shop 1, Ground Floor,
175 Liverpool St
Sydney NSW 2000
P 02 9283 1234
F 02 9382 0303
E hydeparkmc175@outlook.com.au
W www.hydeparkmc.com.au

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Surname: | Given Names: | Date of Birth:

Street Address: | Suburb: | State: | Postcode:

Email:

Birth Sex: ☐ Male ☐ Female ☐ Other ☐ Unknown

Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Transgender ☐ Gender Diverse ☐ Different Identity _____

Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs

Mobile:

Home Tel:

Work Tel:

Ethnicity: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Australian ☐ Others, please state: _____

Smoker: ☐ No ☐ Yes

If Yes, _____ Cigarettes/day

Alcohol Consumption: _____ Glasses/week

Employer: | Occupation:

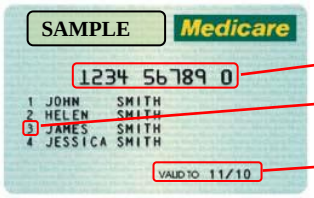
EMERGENCY CONTACT

Name: | Relationship: | Contact No.:

NEXT OF KIN

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 details:

Insurance Name: | Policy Number: | Valid To:

MEDICAL INFORMATION AND OTHERS

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

Hotel Detail (if applicable)

SIGNATURE & DECLARATION

I hereby confirm that the information provided by me herein is true and correct, and that I have read and understood the Standard Terms and Conditions, Patient Information Sheet and the Practice "Did Not Attend" (DNA) Policy.

Sign Here: _____

CONFIDENTIAL

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