BRIGHTON MEDICAL CLINIC
REGISTRATION FORM

Family Name:	**Title:**		
Given Name:	**Preferred Name:**		
Date of Birth:			
Street Address **Suburb and Post Code**			
Postal Address **(if different from above)**			
Home Phone			
Work Phone			
Mobile Phone			
Email			
Medicare Number	_ _ _ _ _ _ _ _ _ _ **Ref No:** _	**Expiry Date**	
DVA Gold / White **Pension Number** **Healthcare Card No.** **(Please circle)**		**Expiry Date**	
Private Health Cover			
Person Responsible for account	Name: _ Date of Birth (for Medicare claiming)_ _ _ _ _ _ _ _ _ _ _ _ _		
Next of Kin (Name, Relationship and Phone number)			
Emergency Contact (Name, Relationship and Phone number of the person we can contact if needed)			

<u>To assist with health initiatives:</u>

Are you of Aboriginal or Torres Strait Islander origin?

☐ Yes ☐No

Other Cultural Background?

☐ Yes ☐No Please identify:____________________

Do you consent to receiving preventative health reminders via SMS?

☐ Yes ☐No