VICTORIA TOWER MEDICAL

Patient Information Form

Please Circle	**Mr/Mrs/Ms/Miss/Master/Dr**	**Male/Female**
Surname		
First Name		
Preferred Name		
Date of Birth		
Street Address		
Suburb		**Post Code**
Home Phone		
Work Phone		
Mobile Phone		
E-mail		
Medicare Number	**Ref No:**	**Expiry Date**
DVA Number	**Gold or White Card**	**Expiry Date**
Pension/Commonwealth Senior Card Number		**Expiry Date**
Concession/Health Care Card Number		**Expiry Date**
Next of Kin	**Name:** **Phone:** **Relationship to Patient:**	
Emergency Contact	**Name:** **Phone:** **Relationship to Patient:**	
Ethnicity	**Language spoken at home?**	**Are you of Aboriginal or Torres Strait Islander Origin?** **YES** **NO**

Occupation: _____

If we need to contact you what is your preferred method of contact:
Home Phone Mobile Phone Work Phone Mail

Consent to SMS reminder Yes No

How did you hear about us?
Walking by Flyer Local paper Referred by friend Other_____

Patient Signature:_____Date:_____