WELCOME TO LANGPARK MEDICAL CENTRE

Thank you for allowing us to look after your health.
To enable us to provide quality care, please complete the following details.

PRIVATE AND CONFIDENTIAL

SURNAME…… **GIVEN NAME(S)……..**
(MR, MRS, MS, MISS, MASTER)

D.O.B …… **SEX:** M/F

MEDICARE NUMBER……..... **EXP. DATE**……/……

PENSION/HEALTH CARE CARD NO: .....EXP. DATE...…/……/….....

VETERAN'S NUMBER……EXP.DATE……

ADDRESS……..

SUBURB…… **POSTCODE**……...

TELEPHONE NUMBER(S): HOME……**MOBILE……**

WORK : ……OCCUPATION…….....

Email address:……

SELF IDENTIFIED CULTURE…….....**ETHNICITY:**…….....
Are you of Aboriginal or Torres Strait Islander YES/NO

NEXT OF KIN

NAME……
CONTACT NUMBER:……
ADDRESS……..
……

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME:.....
CONTACT NUMBER: .....
ADDRESS: .....

Is this a Workcover Claim: Yes/ No (Please Circle)

I agree to pay all accounts within this practice's specified time period. In the event of late payment the practice reserves the right to charge an accounting fee.

Signature……... Date……/……/…….

Do you consent to email /texts for appointments and health reminders? Yes or No

LANGPARK MEDICAL CENTRE RESPECTS AND UPHOLDS YOUR RIGHTS TO PRIVACY PROTECTION UNDER THE NATIONAL PRIVACY PRINCIPLES & CURRENT PRIVACY LEGISLATION (MARCH 2014)