SOUTHERN CROSS
CANNABIS CLINIC

# PATIENT REGISTRATION FORM

| | | | |
|---|---|---|---|
| **Title** | **Mr Mrs Ms Miss Master** | | |
| **Surname** | | | |
| **First Name** | | **Middle Name** | |
| **Date of Birth** | | | |
| **Medicare Number** | **Ref:** | **Expiry Date** | |
| **DVA** | **Gold White** | **Expiry Date** | |
| **Pension Number** | | **Expiry Date** | |
| **Health Care Card Number** | | **Expiry Date** | |
| **Street Address** | | | |
| **Suburb and Post Code** | | | |
| **Home Phone** | | | |
| **Work Phone** | **Email** | | |
| **Mobile Phone** | | | |
| **Marital Status** | Married Single Defacto<br>Widowed Divorced Separated Child | | |
| **Occupation** | **Retired. Previous occupation was:** | | |
| **Country of Birth and Year of Arrival** | | **Ethnicity** | |
| **Next of Kin:**<br>**Name**<br>**Telephone number**<br>**Relationship to next of kin** | | | |
| **Emergency Contact:**<br>**Name**<br>**Telephone Number** | | | |

**To assist with health initiatives - are you of Aboriginal or Torres Strait Islander origin?**

Yes - Aboriginal Yes - Torres Strait Islander ☐ No

**SIGNATURE ……………………………………………….. DATE ……………………………..**

**Thank you for your assistance in helping us provide quality care**

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# PATIENT REGISTRATION FORM

**FOR STAFF USE ONLY:**

1. Name of GP:
2. (If patient is self-referring) Did you discuss your intention to self-refer with your GP?
3. Was your GP supportive of your referral? (Y/N/Unsure):