

Title (please circle): Mr Mrs Ms Miss Mast Dr Other

Surname: _____

First Name (on medicare card): _____

Middle Name: _____

Preferred Name: _____

Date of Birth (dd/mm/yy): ____ / ____ / ____

Sex (please circle): M / F

Address known to Medicare:

Postal Address:

Suburb: _____ PC: _____

Suburb: _____ PC: _____

Are you of Aboriginal or Torres Strait Islander origin? Y/N

Other Cultural Background _____

Home Phone: _____

Work phone: _____

Email: _____

Mobile: _____

(Practice reminders will be sent via SMS to your mobile)

Medicare Number: _____ Ref (no. next to name): _____

Medicare expiry date: ____ / ____ / ____

Do you have a Centrelink Health Care Card or Pension Card? Y / N

(Please Inform reception of your healthcare card no. so you can be bulk billed)

Centrelink Pension / HCC No.: _____ Expiry Date ____ / ____ / ____

(please circle) Pensioner / Health Care / Commonwealth Seniors

Do you have a Department of Veteran's Affairs Card? Y / N

DVA No.: _____

(please circle) Gold / White / Orange

Do you have a My Health Record account? Y/N

Next of Kin: _____

Phone No: _____

Relationship: _____

How did you hear of Norwest General Practice? (Please circle) Word of Mouth / Website / Facebook / Advertising / other

By signing below I give permission for Norwest General Practice to assign

Medicare benefits for services rendered including Consultations and Health Care Plans.

____ / ____ / ____

OFFICE USE	M/C SITD
ENTD	Y / N
BY:	ID: