East Bentleigh Medical Group
873 Centre Road, East Bentleigh, 3165
Telephone 03 9579 2077 Fax 03 9579 3180
www.ebmg.com.au

DR MR MRS MISS MS Master File no _____

First name _____ Surname _____

Aboriginal / Torres Strait Islander Y / N
Other Cultural or Ethnic background Y / N Specify _____

Date of Birth _____ Country of Birth _____

Address _____

_____ Post Code _____

Home phone no. _____ Mobile no. _____

CARDS MUST BE PRESENTED

Medicare no. _ _ _ _ / _ _ _ _ _ / _ Ref no. _ Expiry Date _ _ / _ _ _ _

Pension no. _____ Expiry Date _____

Healthcare card no. _____ Expiry Date _____

Repat no. VX _____ Expiry Date _____

Next of Kin: Name _____

Relationship to Patient _____ Phone no. _____

Emergency contact: Name _____

Relationship to Patient _____ Phone no. _____

Do you consent to being placed on a reminder system? Y / N

Do you consent to disclosure and recording of personal health information? Y / N
(Releasing of medical information to fellow medical colleagues or for professional development)

Signed _____ Date _____