NEW CLIENT REGISTRATION FORM

We welcome, celebrate and respect diversity.
We will always use your preferred name.

TEMPLATE

Title ◯ Miss ◯ Ms ◯ Mrs ◯ Mr ◯ Mx ◯ Dr ◯ N/A Other ◯

Preferred name _____ **Last name** _____

Name listed on Medicare Card _____ **Date of birth** ___ / ___ / ___

Gender ◯ Female ◯ Male ◯ Non-binary ◯ Different identity (specify) _____

(Optional) **At birth, you were recorded as?** ◯ Female ◯ Male

(Optional) **What are your pronouns?** ◯ She ◯ He ◯ They ◯ Other (specify) _____

(Optional) **I use different words to describe my body** ◯ Yes (specify) _____

Sexual orientation ● Heterosexual ◯ Gay/Lesbian ◯ Bisexual ◯ Queer ◯ Prefer not to disclose
◯ Different identity (specify) _____

Country of birth _____
Preferred language _____
Do you require an interpreter? ◯ Yes ◯ No
If Yes, language required _____

Indigenous status
◯ Aboriginal ◯ Torres Strait Islander
◯ Aboriginal/Torres Strait Islander
◯ Non-Indigenous ◯ Prefer not to disclose

Address _____
City/Suburb _____ Postcode _____

Postal address _____
City/Suburb _____ Postcode _____

Contact # _____ **Work #** _____ **Email** _____

Pension/Benefit type
◯ Aged Pension
◯ Care Payment/Pension
◯ Dept Veterans Affairs Pension ◯ Gold ◯ White
◯ Disability Support Pension
◯ Other government pension/benefit
◯ Unemployment-related benefits
◯ No government pension/benefit
◯ Health Care Card holder

I consent to being contacted with reminders ◯ Yes ◯ No

Gender listed with Medicare ◯ M ◯ F ◯ X

Medicare number _____
Ref # _____ Expiry ___ / ___

Pension/Benefit number _____
Expiry ___ / ___

Next of kin
Name _____
Relationship _____
Phone _____

Emergency contact
Name _____
Relationship _____
Phone _____

HERE FOR HEALTH