



# Patient Demographics

Mr Ms Mrs Miss	Surname:	First Name:	Middle Name:
(Please circle one)	Single Married DeFacto Separated Divorced Widowed	Date of Birth:	
Country of Birth:	Is English your main language spoken: Yes No If English is not your main language please identify what is: _____		
Medicare Number:	IRN:	Expiry Date:	
(Please circle one if relevant)	Pension Concession Health Care Concession DVA	Number:	Expiry Date:
Aboriginal: Yes No	Torres Strait Islander: Yes No		
Do you identify yourself as being a member of a particular cultural/religious group? (eg: Maori/ Jehovah's Witness/etc.)			
Telephone Number:	Mobile Number: Are we able to contact you by SMS: Yes No		
Work Number:	Email Address:		
Permanent Address:			
Mailing Address:			
Employer:	Occupation:		
Next of Kin:	Relationship:	Contact Number:	
Emergency Contact Person:	Relationship:	Contact Number:	
Allergies:	Long Term Medication:		
Smoker: Yes No	If Yes, how many per day:		
Quit Smoking: Yes No	Is Yes, what date or year:		
How did you find out about us (Please circle)			
Facebook	Google/Website	Hospital	Friends/Family Other: _____

**Declaration:**

I have seen and read the Privacy Policy of Kununurra Medical.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_