

**Primary Care Psychology  
Registration Form**

**Office Service**



Office Use Only

**PLEASE COMPLETE ALL DETAILS IN PRINTED CAPITAL LETTERS**

|   |  |                                |                          |                             |                           |                                      |  |  |
|---|--|--------------------------------|--------------------------|-----------------------------|---------------------------|--------------------------------------|--|--|
| <b>Sex:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>   |  |                                | <b>Birth Date:</b> _____ |                             |                           | <b>Current Age (in years):</b> _____ |  |  |
| <b>First Name:</b> _____  |  |                                |                          | <b>Surname:</b> _____       |                           |                                      |  |  |
| <b>Office Address:</b> _____  |  |                                |                          |                             |                           |                                      |  |  |
| _____   |  |                                |                          |                             |                           |                                      |  |  |
| <b>Suburb:</b> _____  |  |                                |                          | <b>State:</b> _____         |                           | <b>Postcode:</b> _____               |  |  |
| <b>Home Address:</b> _____  |  |                                |                          |                             |                           |                                      |  |  |
| _____   |  |                                |                          |                             |                           |                                      |  |  |
| <b>Suburb:</b> _____  |  |                                |                          | <b>State:</b> _____         |                           | <b>Postcode:</b> _____               |  |  |
| <b>Postal Address:</b> Same as Home Address <input type="checkbox"/>  |  |                                |                          |                             |                           |                                      |  |  |
| _____   |  |                                |                          |                             |                           |                                      |  |  |
| <b>Suburb:</b> _____  |  |                                |                          | <b>State:</b> _____         |                           | <b>Postcode:</b> _____               |  |  |
| <b>Home Ph:</b> _____   |  | <b>Mobile Ph:</b> _____        |                          |                             | <b>Business Ph:</b> _____ |                                      |  |  |
| <b>Marital Status:</b> Married <input type="checkbox"/> Single <input type="checkbox"/> De Facto <input type="checkbox"/> In relationship <input type="checkbox"/> Widowed <input type="checkbox"/> |  |                                |                          |                             |                           |                                      |  |  |
| <b>No. of Children:</b> _____   |  |                                |                          |                             |                           |                                      |  |  |
| <b>Ages (eg. 6 months, 2, 11, 21):</b> _____  |  |                                |                          |                             |                           |                                      |  |  |
| <b>Religion:</b> _____  |  | <b>Country of Birth:</b> _____ |                          | <b>Main Language:</b> _____ |                           |                                      |  |  |
| _____   |  | _____                          |                          | _____                       |                           |                                      |  |  |
| <b>Medicare Number:</b> _____   |  | <b>Reference No:</b> _____     |                          | <b>Expiry Date:</b> _____   |                           |                                      |  |  |
| _____   |  | (before your name) _____       |                          | _____                       |                           |                                      |  |  |
| <b>Emergency Contact</b>  |  |                                |                          |                             |                           |                                      |  |  |
| <b>First Name:</b> _____  |  |                                |                          | <b>Surname:</b> _____       |                           |                                      |  |  |
| <b>Ph:</b> _____  |  |                                |                          |                             |                           |                                      |  |  |
| <b>Relationship:</b> _____  |  |                                |                          |                             |                           |                                      |  |  |

**Any other important details?** \_\_\_\_\_