

For Centre Staff Completion	Registration Date	Client File Number/ID	
	Index Card Done	<input type="checkbox"/> Yes	R&R pamphlet given
		<input type="checkbox"/> Yes	

CLIENT REGISTRATION FORM



Title	<input type="checkbox"/> Ms	<input type="checkbox"/> Miss	<input type="checkbox"/> Mrs	<input type="checkbox"/> Other (please specify)
Given Name	Last Name			
Street Address				
Town / Suburb	State		Postcode	
Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> (dd/mm/yyyy)
Medicare No.	Person No.	Health Fund No.		
Expiry Date:	(mm/yy)	Expiry Date:	(mm/yy)	

If necessary, can we contact you at the above address and / or below numbers / email:

Home Address	Yes/No		
Telephone No. Home ()	Yes/No	Work ()	Yes/No
Mobile	Yes/No	TTY	Yes/No
Email Address	Yes/No		

Do you have any alternative contacts?

In an emergency, who can we contact?	Name	Phone No.

What country were you born in?

What country have you lived in for most of your life?

Are you Aboriginal / Torres Strait Islander? Aboriginal Torres Strait Is No

What is your cultural background?

What language do you prefer to speak?

Do you need an interpreter? Yes No

If "Yes", for what language?

What is your financial situation? Student Pension/Benefit No Income Other Employed

If "Employed", on what basis? Casual Part time Full time

Do you have a disability or suffer from a long-term health problem? Yes No

If "Yes", what kind of disability or long-term health problem?

How did you hear about our Centre?

<input type="checkbox"/> Friend / Associate / Relative	<input type="checkbox"/> Professional / Organisation
<input type="checkbox"/> Website	<input type="checkbox"/> Newspaper / Magazine
<input type="checkbox"/> Centre Flyer / Pamphlet	<input type="checkbox"/> Other

For Centre Staff Completion	Data Entry Date	Data Entry By