For Centre Staff Completion	Registration Date	Client File Number/ID
	Consent to Audit?	☐ Yes ☐ No

CLIENT REGISTRATION FORM

women's health nsw

Title ☐ Ms ☐ Miss ☐ Mrs ☐ Child ☐ Other (*please specify*) .....

Given Name		*Last Name*	
Have you ever been known by another name? if yes please specify)			
Date of Birth			
Medicare No			Benefit Card No.
Expiry Date:	(mm/yyyy)	Expiry Date: /	(mm/yyyy)

If necessary, can we contact you at the below address, numbers or email? Please specify	**Yes / No**

Street Address			
Town / Suburb		State **NSW**	Postcode **2795**
Email:			

Telephone Home:		**Parent/Carer details (where applicable):**
Work:		**Name:**
Mobile:		**Relationship:** **Phone:**

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 Islander ☐ No

What is your cultural background? ☐ Australian or Other..... (*please specify*)

What language do you prefer to speak? ☐ English or Other..... (*please specify*)

Do you need an interpreter? ☐ Yes ☐ No

If "Yes", for what language?

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

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

Do you consider yourself? ☐ Heterosexual ☐ Bisexual ☐ Lesbian ☐ Other

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?

☐ Friend / Associate / Relative

☐ Centre Flyer / Pamphlet

☐ Newspaper / Magazine

☐ Professional / Organisation (please specify)

.....

☐ Other (please specify)

Websites

☐ Ours

☐ Women's Hlth NSW

☐ Other (please specify)

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For Centre Staff Completion	Data Entry Date	Data Entry By