

New Patient Information Form



FIRST NAME:		MIDDLE NAME:		PREFERRED NAME:	
SURNAME: (MUST BE AS IT APPEARS ON MEDICARE CARD)				MRS MS MISS MR MAST DR	
DATE OF BIRTH:					
MEDICARE NUMBER:		Ref No.		Expiry Date: /	
CONCESSION CARD: No: (Pension / HCC / Veterans - Please Circle)		Ref No.		Expiry Date: / /	
RESIDENTIAL ADDRESS:		Suburb:		Post Code:	
POSTAL ADDRESS:		Suburb:		Post Code:	
HOME PHONE:		WORK:		MOBILE: We offer SMS Reminders for Appointments (Please Tick) <input type="checkbox"/>	
EMAIL:					
MARITAL STATUS: Single Married Divorced Separated Defacto Widowed (Please Circle)					
OCCUPATION:					
DETAILS OF YOUR NEXT OF KIN			DETAILS OF YOUR EMERGENCY CONTACT		
NAME:			NAME:		
RELATIONSHIP TO PATIENT:			RELATIONSHIP TO PATIENT:		
PHONE NUMBER:			PHONE NUMBER:		

Cultural Background (Please complete below, it's important information)

☐ Aboriginal ☐ Torres Strait Island ☐ Australian ☐ Other (Specify).....

Social History

Tobacco - per day or Ceased Smoking -date..... ☐ N/A

Alcohol - Glasses per week ☐ N/A

Height: Cm Weight: Kg

Do you have any allergies or are you sensitive to any drugs or dressings: YES NO

If yes please specify :.....

Your Health History – Do you have or had a history of?

Operations- ☐ Hypertension- ☐ Asthma- ☐ Chronic Illness- ☐ Diabetes- ☐ Other- Unaware- ☐

*I understand that my personal health information will be disclosed to other health providers directly involved in my personal health care or medical treatment. If you would like further information, please speak to your doctor.

Our practice provides our patient with preventive care and early case detection reminders, e.g. immunisations, annual health check, skin checks and pap smears. I consent to being contacted with reminders as part of the quality improvement activities at this practice.

YES ☐ NO ☐

Signature.....

Date-/...../ 2020.

If not patient signing – Your name (please print).....