New Patient Registration Form

Please Circle Title: Mr. Mrs. Ms. Miss. Mast. Gender: M / F / Other

First Name: ______________________________ Family Name: _________________________________

Date of Birth: ___/___/____ Preferred Name: _____________________Occupation: ________________

Address: ____

Suburb: ________________________________ Postcode: ________________

Postal Address (if different to above): ____

Suburb: _______________________________ Postcode: ________________

Mobile: _____________________ Home Phone: ________________ Work Phone: _____________________

Email Address: ____

Please Circle: Are you an Aboriginal, Torres Strait Islander or both? Yes / No

Cultural Background/ Ethnicity: ____

Medicare Number: __ __ __ __ __ __ __ __ __ __ Reference Number: _____

Expiry Date: _____/_____/_____ Marital Status: ______________________________

Please Circle: Pension / Health Care Card Number:

____ Expiry: _______________________

DVA Card Veteran Affairs **Please circle:** Gold / White

____ Expiry: _______________________

Next of Kin Name: _____________________________ Relationship: _____________

Contact Number: ____

Emergency Contact Name: ______________________________ Relationship: _____________

Contact Number: ____

Do you consent to SMS or other relevant medical reminders? Yes / No

In signing your patient registration, you are consenting to be seen by a GP of the practice and receiving appointment reminders and other relevant medical reminders by SMS

How did you find out about us? E.g.) Instagram, Internet, Pamphlet or Family ________________________

Signed: ____________________________________ Date: _______________________________

Patient Health Summary

First Name: ________________________ Last Name: _____________________________

Date of Birth: ______/_______/________

Current Medical History

Do you have any Allergies? *Please Circle:* YES / NO / UNKNOWN

If '*Yes'* Please list down known allergies you may have.

____

Are you currently taking any medications?

Please Circle: YES / NO

If '*Yes'* Please list down current medication.

____

____

Are you currently using any complementary or alternative medicines or therapies?

Please Circle: YES / NO

If '*Yes'* Please list down current medications or therapies.

____

____

Past Medical History

Do you smoke? YES / NO

If '*no*' have you ever smoked? YES / NO

If '*yes*' how long ago did you quit? __________

Do You Drink Alcohol? YES / NO

Frequency ________________________

Have you tried Quitting YES / NO

Have you ever had or have any of the conditions below? If '*Yes'* Please Circle.

Diabetes Kidney Disease Asthma Bowel Cancer Breast Cancer

High Blood Pressure Heart Problems Epilepsy Depression/Anxiety

Other mental health

Other: ___________________

Is there a Family History of any of these conditions? If 'Yes' Please Circle.

Diabetes Kidney Disease Asthma Bowel Cancer Breast Cancer

High Blood Pressure Heart Problems Epilepsy

Other: ______________________________

If 'Yes' state relationship to you ____________________________________