



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 _____