



## 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.

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Are you currently taking any medications?

Please Circle: YES / NO

If 'Yes' Please list down current medication.

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

Please Circle: YES / NO

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

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### **Past Medical History**

Do you smoke? YES / NO

Do You Drink Alcohol? YES / NO

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

Frequency \_\_\_\_\_

If 'yes' how long ago did you quit? \_\_\_\_\_

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 \_\_\_\_\_