New Patient Registration

We are committed to providing our patients with the best care. To do this it is essential that your health record is up to date and accurate.

Could you please assist us by completing the following:

Title **M ☐ F ☐**	☐ **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐ **Mast** ☐ **Other** _____	**Marital Status**	
Surname			
First Name		**Middle Name**	
Preferred Name		**Date of Birth**	
Postal Address			
Residential Address			
Home Phone		**Work Phone**	
Mobile Phone			
SMS reminders will be sent to all patients with mobile phones the day before their scheduled appointment. You can opt out of this service by advising reception staff.			
Email			
Medicare Number		**Ref. No.**	**Expiry Date**
DVA Gold / White (Please circle)			**Expiry Date**
Pension Number			**Expiry Date**
Health Care Card Number			**Expiry Date**
Next of Kin Name/phone/relationship			
Emergency Contact Name/phone/relationship			

To assist with health initiatives please advise your ethnicity:

☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Aboriginal & Torres Strait Islander**

☐ **Australian** ☐ **Other – please state** _____

PTO

YOUR HEALTH HISTORY - do you have or have you had a history of?

☐ Operations (please list details including year)

_____

_____

_____

☐ Asthma

_____

☐ Diabetes

_____

☐ Hypertension

_____

☐ Chronic illness

_____

☐ Other

_____

_____

_____

Do you have any allergies or are you sensitive to drugs or dressings:

☐ Yes (please list below) ☐No

_____

Current medications (including over the counter medications, vitamins and minerals):

_____

_____

_____

Social history

☐ Tobacco _____ daily / weekly or Ceased Smoking - date _____

☐ Alcohol _____ daily / weekly / monthly (circle applicable)

☐ Drug use _____ (type and frequency)

Height: _____ cms **Weight:** _____ kgs

For those 65 years and older: when was the last time you had:

Influenza vaccine	Date_____	☐ not sure	☐ never
Pneumococcal pneumonia vaccine	Date_____	☐ not sure	☐ never

Females: When did you last have?

Pap smear	Date_____	☐ not sure	☐ never

Males: When did you last have?

An overall check up	Date _____	☐ not sure	☐ never

I consent to the release and receiving of medical information relevant to my care and treatment between health service providers: ☐ Yes ☐No

Date:_____**Signature:**_____