New Patient Registration Form:

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

Part A: The following information must ALL be completed

Title: (please circle) MR / MRS / MS / MISS / MASTER Other: _____

Surname: _____ First Name: _____

Middle Name: _____ Date of Birth: ____ / ____ / _____

Street Address: _____

Suburb: _____ Postcode: ___ ___ ___ ___

Home Phone: (__ __) _____ Mobile Phone: _____

Work Phone: _____ Email: _____

Medicare Number: __ __ __ __ __ __ __ __ __ __ Ref No: ____ Exp: _____ /_____

Pension/HCC Number: _____ Exp: _____ / _____ **(Centrelink)**

Torres Strait Islander ? (Please Circle) YES / NO Aboriginal ? (Please Circle) YES / NO

Other Ethnic Background: _____ Occupation: _____

Next of Kin: _____ Relationship to Patient: _____

Mobile: _____ Home: (__ __) _____

Part B: The following information must ALL be completed

Allergies: _____

Your Health History. Do you have or have you had a history of:

[ ] Operations: Details: _____

[ ] Asthma [ ] Diabetes _____ [ ] Hypertension [ ] Cholesterol _____

[ ] Epilepsy [ ] Heart Disease [ ] Stroke [ ] Chronic Illness _____

Please tick the appropriate box/es:
[ ] I have never smoked [ ] I have quit smoking. Date quit: _____ [ ] I am a current smoker - Please tick: [ ] 1 – 5 [ ] 5 – 10 [ ] 10 – 20 [ ] 20 or more per day

[ ] I do not drink alcohol [ ] I drink daily - How many per day: _____ [ ] weekly drinker - How many per week: _____
Family History: _____
_____