

NEW PATIENT INFORMATION FORM

CHART No/

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

TITLE: Mr / Mrs / Miss / Ms / Master / Dr / other

MARITAL STATUS : Single / Married / Divorced / Defacto

FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICARE No/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ref: \_\_\_\_\_\_ Exp Date:\_\_\_\_\_\_\_\_\_\_\_\_

DEPARTMENT OF VETERAN AFFAIRS CARD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp: \_\_\_\_\_\_\_

CONCESSION CARD: (Pension / HCC)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ref:\_\_\_\_ Exp\_\_\_\_\_\_\_\_

RESIDENTIAL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBURB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOBILE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU SMOKE : YES / NO HOW MANY A DAY ( )

DO YOU DRINK ALCOHOL: YES/ NO HOW MUCH WEEKLY ( )

WEIGHT (Kgs) Height (Cms)

COUNTRY OF ORIGIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NEXT OF KIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TEL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TEL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU IDENTIFY AS BEING: ABORIGINAL ORIGIN YES/ NO

TORRES STRAIGHT ISLANDER YES / NO

Medical History

Diabetes Y/N Cancer Y/N Asthma Y/N

Hypertension Y/N Renal Impairment Y/N

(By signing this form, you consent to bill Medicare for your visit)

Signature ­­­­­­­­­­------------------------------------------