**NEW PATIENT REGISTRATION FORM**

**Title (Mr / Mrs / Miss / Dr / Other: ) FULL Name:**

**Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Male / Female Occupation:**

**Address:**

**Town/Suburb: State: Postcode:**

**Contact Phone No. (Home): (Mobile):**

**Email Address:**

**Allergies:**

**Smoker: Yes / No If yes, roughly how many per week? \_\_\_\_**

**Alcohol: Yes / No If yes, roughly how many standard drinks per week? \_\_\_\_**

**Medicare No:**   **Ref. No: Expiry:**

**OSHC Card Member No: Expiry Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

**Concessions Health Care Card No: Expiry Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

**Centrelink Pensioner Card No: Expiry Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

**Veteran Card No: Expiry Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

**Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Select if you would like to be identified by your cultural background: N/A Aboriginal / Torres Strait Islander**

**Next of Kin:**

**Name: Contact No: Relationship:**

**Emergency Contact:** (If different from next of kin)

**Name: Contact No: Relationship:**

**How did you hear about us? O Internet Walking Past Word of Mouth Referred by Existing Patients**

**Personal Information Consent Form:**

Information collected by your doctor will be used to provide you with quality patient care. Your personal health information will be keep confidential and will not be disclosed, unless required by law, to any third party without your consent either verbally or in writing. I consent to the collection of medical information for the purpose of providing me with quality patient care.

I am aware of my rights to access information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given explanation in these circumstances.

**Patient / Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_