New patient Registration form:

Surname:	First Name:
Date of Birth:	Gender
Address:	PPSN:
Mobile No:	Landline:
Do you consent to text messaging?	Yes No
Email Address:	

Next of Kin:

Name:	Relationship to patient:
Contact telephone number:	

Previous/Current GP name:	GP clinic:
Reason for changing GP:	
Medical card/doctor visit card number:	
If you have private health insurance, please complete the following:	
Policy number:	Insurance provider:

Medical History

Current Medical Condition	Previous Surgical History
1.	1.
2.	2.
3.	3.
4.	4.

Have you any family history/illnesses we should be aware of:

____

____

Medications

Please list any medications you are currently taking including the dose:	
1.	5.
2.	6.
3.	7.
4.	8.

Do you have any allergies to medication: **Yes** **No**

If yes what medication?___________________________________

What was the reaction?___________________________________

Social History:

Occupation:			
Are you a smoker?	Yes / No	Are you a drinker?	Yes / No
If yes how many cigarettes do you smoke per day?		If yes what do you drink?	
How old were you when you started smoking?		How many drinks would you have a week? Over how many days?	__________________