New Patient Form	
Your Details	
Title	☐Dr ☐ Mr ☐ Mrs ☐ Ms ☐Miss ☐Master
Surname	
Given Name	
Preferred Name	
Date of Birth	
Birth Gender	☐ Male ☐ Female ☐ Other
Gender Identity	☐ Male ☐ Female ☐ Other
Culture	☐ Australian (Non Indigenous) ☐ Aboriginal ☐ Torres Strait Islander ☐ Thai ☐ Brazilian ☐ Vietnamese ☐ Chinese ☐ Indian ☐ Other: ______
Are you CTG Registered (ATSI patients only)	☐ Yes ☐ No ☐ Unknown
Head of Family Name and Date of birth	Name: ______ Date of Birth: ______
Street Address	
Suburb and Post Code	
Contact Number	Home Line: ______ Work Number: ______ Mobile: ______
Email Address	
Medicare	Card Number: ______ Ref Number: ______ Exp: ______
Pension/ Health Care Card	☐ Aged Pension ☐ Health Care Card ☐ Other Number: ______ Exp: ______
DVA Card	☐ Gold ☐ White ☐ Orange Number: ______
Private Health Fund and Number	Company: ______ Number: ______
Religion	
Do you require an interpreter?	☐ Yes ☐ No
Next of Kin	Name: ______ Address: ______ Contact number: ______ Relationship: ______

Emergency Contact	Same as NOK? ☐ Yes ☐ No Name: __________ Address: __________ Contact number: __________ Relationship: __________
Family and Social History	
Occupation	
Family Medical History	**Mother** ☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ Cancer (Type): ☐ Depression ☐ Stroke ☐ Other: ☐ Unknown (EG. Adopted) **Father** ☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ Cancer (Type): ☐ Depression ☐ Stroke ☐ Other: ☐ Unknown(EG. Adopted)
Alcohol Intake	☐ Non-drinker Days per week ________ Drinks per day ______
Tobacco	☐ Non-smoker ☐ Smoker – Year Started: ☐ Ex-smoker- Year Stopped:
Your Health	
Do you have or have you had a history of:	☐ Operations ☐ Asthma ☐ Diabetes ☐ Hypertension ☐ Chronic Illness ☐ Other
Do you have any allergies or are you sensitive to drugs or dressings	☐ No ☐ Yes – Reaction:
Immunisations	Tetanus ☐ Yes- Date Given Influenza ☐ Yes- Date Given Pneumococcal ☐ Yes- Date GIven
If completing this form for a child, are their immunisations up to date?	☐ Yes ☐ No ☐ Not sure
For those 65 years and older, when was the last time you were immunised for:	Influenza – Date ☐ Not sure ☐ Never Pneumococcal – Date ☐ Not sure ☐ Never Pneumonia – Date ☐ Not sure ☐ Never Shingles – Date ☐ Not sure ☐ Never
Do you have a My Health Record?	☐ Yes ☐ No
This practice is committed to maintaining the confidentiality of your personal health information. It is our policy to ensure that this information is only available to authorised member of our staff. This can be found on your website.	
Patient Signature	
Date	