New Patient Information Form

We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

Title (Mrs, Mr etc)				
First Name				
Surname				
Date of Birth				
Address				
Home Phone				
Mobile Phone				
Email				
Medicare Number (Ref: is number next to name)		**REF**	**Expiry Date**	
Pension Number			**Expiry Date**	
Health Care Card Number			**Expiry Date**	
Are you an Aboriginal or Torres Strait Islander?	**No** ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Aboriginal & Torres Strait Islander** ☐			
Marital Status	**Single** ☐ **Married** ☐ **Defacto** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐			
Occupation				
Ethnicity (Nationality) Country of birth				
Next of Kin/ Emergency Contact (Name, Relationship and Phone number)				
Allergies (Please list any allergies you have).	**YES / NO**			
Do you smoke?	**YES / NO**	**If so, how many a day?:**		
Do you consume alcohol?	**YES / NO**	**If so, how many a glasses day?:**		
Measurements	**Height in cms:**	**Weight in kgs:**		
Family History (Please list any past history of disease in your family).				
For females Obstetric History	When was your last pap smear?			

I agree to allow Barrymore Medical Centre to collect information relevant to medical care and treatment from the doctors. I consent to the use of my mobile number for SMS to contact me for reminders and recalls.

Patient signature: _____ Date: _____