NEW PATIENT INFORMATION FORM

755 Sayers Road Medical Centre

The Information will assist our Doctors to continue to provide efficient care. On completion, this information will be entered as part of your medical history

Title:	**Mr Mrs Miss Ms Master**		
Surname:		**First Name:**	
Date of Birth:	/ /	**Gender:**	**F M**
Measurements:	**Height:**	**Weight:**	
Address:			
Contact No:	**(H):** **(W):** **(M):** **Would you like SMS reminders?** ☐ **Yes** ☐ **No**		
Email:			
Medicare Card No.	**Ref:** **Expiry Date:**		
Concession Card / Pension / DVA No.	**Expiry Date:**		
Occupation:			
Country of Birth:			
Are you Aboriginal or Torres Strait Islander	☐ **Yes** ☐ **No**		
Next of Kin:	**Name:** **Relationship:** **Contact No:**		
Emergency Contact:	**Name:** **Relationship:** **Contact No:**		

I consent to the collection of this health information and understand it will be treated in accordance with "The Privacy Act"

Signature: **Date:**

Do you have any allergies or are you sensitive to drugs? ☐ **Yes** ☐ **No**

(If Yes, please provide info)

Name of Medication: **Reactions:**

Your History ☐ **Asthma** ☐ **Chronic Illness** ☐ **Diabetes** ☐ **Hypertension** ☐ **Other**

Please give details:

Your Family History ☐ **Asthma** ☐ **Chronic Illness** ☐ **Diabetes** ☐ **Hypertension** ☐ **Other**

Please give details:

Smoking:	☐ **Smoker** ☐ **Ex-smoker** ☐ **Never Smoked**
Alcohol:	☐ **Non drinker** ☐ **Yes – how many: _____ day / _____ week / _____ month**

How did you find out about us? (circle): Family / Friend / Website / Passing by / Other_____