NEW PATIENT INFORMATION

☐ Mr ☐ Mrs ☐ Miss ☐ Master (please tick)

SURNAME: ----------

GIVEN NAMES: ---------- **DOB:** ----------

If patient is a child, please give name of parent: ----------

ADDRESS: ----------

PHONE: Home ---------- **Work** ---------- **Mobile** ----------

Medicare No: / / **No 1, 2, 3, etc:** **Valid To**: /

Pension Health Card No: ----------

Veteran's Affairs No: ----------

Name of Health Fund: ---------- **Membership No**: ----------

Health Fund Level of Cover **Top Cover ☐** **Basic Cover ☐** **Extras Cover only ☐**

Name of referring Doctor: ----------

Name of GP (*if different* from referring doctor)----------

Because of Federal Privacy Laws would you *please supply a password for you file.* This means if you or anyone on your behalf phones for results we will ask for this password *before* releasing any information.

PASSWORD:---------- **(e.g. dog or cat's name or number) – something you'll remember.**

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Name (*please* write again): ---------- **Age:** ----------

Have you had, or are you being treated for, any of the following:

BLOOD PRESSURE	**Yes/No**	**HEART PROBLEMS**	**Yes/No**
STROKE	**Yes/No**	**DIABETES**	**Yes/No**
LUNG OR CHEST	**Yes/No**	**DO YOU SMOKE?**	**Yes/No**

Do you have any other problems? (Give brief details)----------

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Are you taking any pills or medicines? (Please name)----------

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What operations have you had?----------

Are you *allergic* to anything? (if yes, please name) ----------
Do you have any problems with bleeding particularly related to operations or teeth extractions Yes/No