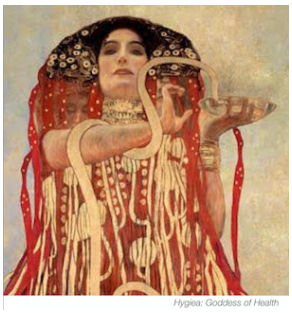

North Carlton Doctor
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New Patient Registration Form

We are committed to providing our patients with the best care. To do this it is essential that your health records are kept up to date and accurate. Please complete the following.

Personal Information

Title	
Surname	
Given Names	
Date of Birth	

Contact Details

Home Address	
Postal Address	
Home Phone	
Mobile Phone	
Email	
Occupation	

Alternative Contact Details

	Next of Kin	Emergency Contact
Name		
Phone Number		
Relationship		

Card Details

Medicare	No.:	No. to the left of your name:	Expiry:
Health Care Card	No.:		Expiry:
Pension Card	No.:		Expiry:

Background

This section is **optiona**l and is used to tailor health initiatives for individual patients

1. Are you Aboriginal and/or Torres Strait Islander? No Yes
2. Are you from a cultural or linguistic diverse background? No Yes Feel free to specify_____

Relationship Status (optional)

Single Married De-facto Divorced Separated Widowed

Medications

Please list all medications you are taking at the moment, including herbal supplements/remedies.

Medical History

Please list as much of your medical history as you can including operations and conditions

Allergies

Do you have any general allergies, drug allergies or allergies to dressings?

☐ No ☐ Yes, Please explain _____

Family History

List any relevant family medical history

_____

_____

_____

_____

_____

Social History

Do you drink alcohol? Never Occasionally Regularly Daily

Are you a smoker? No Yes How many per day? ____ How long have you smoked? _____

Do you use recreational drugs? No Yes _____

Children's Immunisations

If filling this form out for a child, are immunisations up to date? No Yes

Females

Have you had a Pap Smear? No Yes If yes, approximate date of last Pap Smear? _____

Have you had a Breast Screen? No Yes If yes, approximate date of last mammogram? _____

Signature: _____

Date: ___/___/___

If you have completed this form as a parent/guardian of a child:

Print Name: _____ Relationship: _____