JOSEPH BANKS CRESCENT MEDICAL CENTRE

NEW PATIENT INFORMATION

(Please use BLOCK LETTERS)

SURNAME:_____ **FIRST NAME:** _____

KNOWN AS: _____ **D.O.B.** _____

ADDRESS:_____

_____**POST CODE:**_____

If new patient is a child please fill in parents full names

MOTHER	FATHER
NAME: _____	**NAME:** _____
MOBILE: _____	**MOBILE:** _____

CONSENT TO SMS YES ☐ **NO** ☐ for appointment **confirmation only**

OCCUPATION: _____

WORK PHONE NO: _____ EMERGENCY PHONE NO._____

COUNTRY OF BIRTH: _____

ABORIGINAL ☐ **TORRES STRAIT ISLANDER** ☐ **OTHER** _____

MAIN LANGUAGE SPOKEN IF NOT ENGLISH:_____

MEDICARE NO. _____ **REF. NO.** _____**EXP.**_____

PENSION/HCC CARD:_____ **EXP.**_____

VETERANS AFFAIRS: _____ **GOLD/WHITE (CIRCLE)**

NEXT OF KIN: _____**RELATIONSHIP:** _____

CONTACT DETAILS: _____

EMERGENCY CONTACT DETAILS: NAME:_____

RELATIONSHIP: _____ **PHONE NO.:**_____

To assist the Doctor please list current medications and/or allergies.

Smoker: ☐ NO ☐ YES How many per day _____

Medications: **Allergies:**

_____ _____

_____ _____

_____ _____

Previous Dr's Name _____

Previous Dr's Address _____

Signed: _____ **Date first seen by JBMC:** _____

Created on 20/07/16 1:01:00 PM Created by Margaret/Users/ranjanasrivastava/Dropbox/New Patient Information/NEW PATIENT INFORMATION SHEET.docx Amended 14/08/06 Amended 29/04/2013,14/10/14, Amended 30/03/2016