Together MEDICAL
family practice

New Patient Form

Title: Mr / Mrs / Ms / Miss / Mast / Dr / Other _____

Surname: _____ **First Name:**

Date of Birth: _____/_____/_____ **Gender:** Male / Female / Other

Ethnicity: _____ **Aboriginal/Torres Str Islander:** Yes / No

Marital Status: _____ **Occupation:** _____

Address: _____

Suburb: _____ **Postcode:** _____

Home Phone: _____ **Mobile No:** _____

Email: _____

Do you have any of the following cards? (please circle)

Health Care Card **Pension Concession Card** **Seniors Health Card** **DVA**

Card Number: _____ **Expiry:** _____/_____/_____

DVA Number: _____ White / Gold / Lilac / Orange

Next of Kin: _____

Contact No: _____ **Relationship:** _____

Emergency Contact: _____

Contact No: _____ **Relationship:** _____

I agree to allow Together Medical Family Practice to collect Information relevant to my medical care and treatment from their Doctors.
I consent to the use of my mobile number for SMS or my Email address to contact me for reminders, recalls, health alerts and/or other relevant health information.

Signature: _____ **Date:** _____/_____/_____

Medications: _____

Allergies: _____

Smoking Status: Non smoker / Ex Smoker / Smoker - no per day: _____

Drink Alcohol: Yes / No If yes, days per week? _____ drinks per day? _____

Family History: _____

Pre Existing Conditions: _____

Height: _____ **Weight:** _____

Females, Last Cervical Screen: _____ Unsure / Never