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Kanwal Village Medical Centre
Shop 1, Kanwal Village Shopping Centre 258 Wallarah Rd., Kanwal NSW 2259
Tel: (02) 4393 6660 Fax: (02) 4393 6615

New Patient Information Form

Personal Information:

Patient Name: …………………………………………………………………….. DOB: ……………/………../……….
Title First Mid Last

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ………………………………

Occupation …………………………………...

Cultural Background - please circle: Torres Strait Islander Aboriginal Australian Other:…………………

Phone (Home)…………………………… (Work): …………………………….. (Mobile): …………………………………

Postal Address: ……………………………………………………………………………………………………..
No. Street

………..
City State Post Code

Medicare number: …………………………………….. Patient reference number………………..

Expiry Date: …………/…………/…..…..

Healthcare card number: ……………………………… Expiry Date: ……..… /…………/………..

Health Information:

Have you ever had any of the following? Please tick those that apply:

☐AIDS(HIV)
☐Anemia
☐Arthritis
☐Artificial Joints
☐Asthma
☐Cancer
☐Diabetes
☐Dizziness
☐Epilepsy
☐Glaucoma
☐Hay Fever
☐Head Injuries
☐Heart Disease
☐Heart Murmur
☐Hepatitis
☐High Blood Pressure
☐Jaundice
☐Kidney Disease
☐Liver Disease
☐Mental Disorders
☐Osteoporosis
☐Pacemaker
☐**Pregnancy**
Due date: …………..
☐Radiation Treatment
☐Respiratory Problems
☐Rheumatic Fever
☐Rheumatism
☐Stomach Problems
☐Stroke
☐Taking Warfarin
Thyroid ☐ Hyperactive
☐ Hypoactive
☐Tuberculosis
☐Tumors
☐Ulcers
☐Venereal Disease

- Allergies: …….
- Other health problems: ………………………………………………………………………………………….
……..
- Are you under the care of a regular GP at present? ☐ Yes ☐ No
- If yes, please list the practice name ………………………………………….Doctor's name:………………………….
- List any medication, pills or drugs being taken:
……..
……..
……..

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend or relative

☐Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other…………………………….

Next of Kin

Name: ……………………………………………………………………………………………………….…………………

Phone (mobile): ……………………………….. Alternative number…………………………………………………..

Address: ……..
Street City Post Code

Relationship to Patient: ……………………………………………..

Emergency Contact

Name:………

Address:……

………

Phone:……………………………………………………………………..

Alternative phone:………………………………………………………..
.
Relationship to Patient:……………………………………………….

To my best of my knowledge, all of the preceding answers and information provided are true and correct.

……………………………………………… Date: …………/…………/……………

Signature of patient, parent or guardian