Kanwal Village Medical Centre
1/258 Wallarah Rd
Kanwal NSW 2259
Tel: (02) 4393 6660 Fax: (02) 4393 6615

New Patient Information Form

Personal Information:

Title: Mr Mrs Ms Miss Mast Dr

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

Male Female

Occupation: ……

Ethnicity: Aboriginal Torres Strait Islander Australian Other: *(please specify)*……

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

Postal Address: ……
No. Street

……
Suburb State Post Code

Medicare Number:

☐☐☐☐ ☐☐☐☐☐ ☐ **Ref #** ☐ Expiry: ____/____/____

Concession Card Number **Pension Card or Health Care Card**

☐☐☐☐☐☐☐☐☐☐ Expiry: ____/____/____

DVA Card Number (Veterans Affairs)

☐☐☐☐☐☐☐☐☐ **DVA** Gold Card ☐ White Card ☐ Expiry: ____/____/____

Health Information:

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

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:

……..

PLEASE FILL OUT INFORMATION ON 2ND PAGE

……

Referral Information

Whom may we thank for referring you to our practice?

Letter Box Flyer Local Newspaper Another patient, friend or relative Local Directories Internet
Yellow/White pages Other……

Next of Kin (Different from Emergency Contact):

Name:……
First Last

Address:……
No Street

……
City State Postcode

Contact Phone Number:……

Relationship: ……

Emergency Contact:

Name:……
First Last

Address:……
No Street

……
Suburb State Postcode

Contact Phone Number:……

Relationship: ……

SMS reminders

✓ I acknowledge that this consent may be removed at my request but that until such consent is revoked, I may receive text messages from Kanwal Village Medical Centre as a reminder of appointments or services needed.

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

…… Date: ……/……/……..
Signature of Patient, Parent or Guardian