NEW PATIENT REGISTRATION FORM

Hornsby MEDICAL PRACTICE

Could you please assist us by completing the following:

Title	☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss
Surname	
First Name	
Date of Birth	

Street Address			
Suburb and Post Code			
Home Phone		**Mobile Phone**	
Occupation		**Work Phone**	

Medicare Number	**Ref #:**	Expiry:
☐ **DVA Gold** ☐ **DVA White /Health Card/Pension No:**		Expiry:

Emergency Contact	**Name**	**Phone**
Relationship to Patient		

Reminder Systems Our practice provides our patients with preventive care and early case detection reminders **e.g. immunisations, annual health checks, skin checks and pap smears.**

Do you wish to have any relevant health reminders sent to you? ☐ Yes ☐ No

To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?

☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander

Ethnicity

Do you have any allergies or are you sensitive to drugs?

☐ No ☐ Yes. Please elaborate:

Do you use any of the following: (list amount where appropriate)

Alcohol	☐ No.	☐ Yes. Days per week ____	Standards per day ___________
Tobacco	☐ No.	☐ Yes. Number per day ______	☐ Ex-smoker year ceased _________

Have any members of your family had:

☐ No Significant Family History

☐ Diabetes	☐ Mother	☐ Father
☐ Mental Illness /Depression	☐ Mother	☐ Father
☐ Cancer	☐ Mother	☐ Father
☐ Heart Disease	☐ Mother	☐ Father

☐ I consent to the use of my health information by Hornsby Medical Practice and other health providers involved in their medical treatment and health care. I offer to assign my rights to Medicare benefit payable to the doctors of Hornsby Medical Practice who will render the medical service.

X ______________________________ Date ___/___/___