medicalpractice.com.au
Dee Why – Sydney CBD –
Neutral Bay

Side A – Please complete all sections

Title	Given Name

Middle Name

Surname

Date of Birth
(dd/mm/yyyy)

Birth Sex.
Male ☐ Female ☐ Other ☐

Gender Identity.
Male ☐ Female ☐ Other ☐

Are you Aboriginal or Torres Strait Islander?
Yes ☐ No ☐ Both ☐

Country of Birth

Street Address

Suburb	State	P/Code

Mobile Phone

Email Address

Medicare Number | Ref Number (in front of your name)

Expiry Date Month / Year

OSHC / Overseas Students

Expiry Date Month / Year

Pension Card ☐ / DVA ☐ | Ref No

Expiry Date Month / Year

Occupation

Employer

DO YOU HAVE ANY ALLERGIES? NO ☐

If yes,
Substance Reaction

Do you give consent for us to upload your file to "My Health Record"
Yes ☐ No ☐

Emergency Contact
First Name

Surname

Phone

Patient Signature

Side B – Please complete as much as possible.

Smoking Status
☐ Non Smoker
☐ Ex Smoker
Years smoked.....
☐ Current Smoker
Cigarettes per day.....

Alcohol Consumption
☐ Non Drinker
☐ Ex Drinker
Years alcohol.....
☐ Current Consumption
Drinks per day.....

How did you find us?
Recommendation ☐, Walk Past ☐,
Patient at our other practice ☐, Google ☐,
Other:

What is your height and weight (if known)?
Height: Weight:

When was your last CST (Pap smear)?
N/A: ☐ Date:

CURRENT MEDICATIONS

Medication	Dose

MEDICAL HISTORY

Year	Condition / Operation

FAMILY HISTORY

Member	Condition / Cause of death
Mother:	
Father:	
Grandparents:	
Siblings:	

.....

Administration Only

File Number

Date Form Completed

Processed By