Albert St Medical Centre
Phone: (02) 6552-5533
Fax: (02) 6552-4249
Email: admin@albertstmc.com
Address: 78 Albert Street, PO Box 834,
Taree NSW 2430

NEW PATIENT INFORMATION FORM

Please complete the following history as best you can. This is essential to ensure your medical records are up to date and accurate.

First Name: _____ Surname: _____

Date of Birth: _____

Home Phone: _____ Work Phone: _____ Mobile: (SMS) _____

Address: _____

Email address: _____

***Please give your Medicare /HCC/Pension card to the Receptionist to enter on your records**

OR FILL IN HERE.

Medicare No: _____ Expiry Date: _____

Health Care /Pension Card: _____ Expiry Date: _____

DETAILS OF YOUR NEXT OF KIN or EMERGENCY CONTACT

First Name: _____ Surname: _____

Relationship to patient: _____

Phone No: _____

How did you hear about our Practice? _____

Are you of Aboriginal or Torres Strait Islander origin? Yes ◯ No ◯

Are you of other origin? Please specify. _____

Do you have any allergies or are you sensitive to drugs or dressings: Yes ◯ No ◯

(If yes please list below) _____

Your Health History

Do you have or had a history of?

Chronic Illness ☐ Hypertension ☐ Asthma ☐

Mental Illness ☐ Diabetes ☐

Operations (Please list) _____

Other (Please list) _____

Current Medications: (including over the counter medications, vitamins and minerals) _____

Immunisations up to date? Yes ◯ No ◯ Don't Know ◯

Have you considered H1N1 (Swine Flu) vaccination? Yes ◯ No ◯

Do you consent to us leaving a message on your phone stating that we are ringing from the medical practice? Yes ◯ No ◯

Signature: _____ Date: _____

(If under the age of 16, parent or guardian to sign, stating relationship to patient)