New Patient Form

TRINITY CARE
FAMILY PRACTICE

Title | Surname | Given Name | Preferred Name

Date of Birth | Gender | Marital Status

Medicare Card Number | Reference Number | Expiry Date

Pension, Health Care, or DVA Number | Type | Expiry Date

Occupation

Home Address | Postcode

Postal Address | Postcode

Telephone Number | Work Number | Mobile Number

Email

Next of Kin Name | Phone Number | Relationship

Emergency Contact Name | Phone Number | Relationship

Are you of Aboriginal or Torres Strait Islander origin?

No ☐ Aboriginal ☐ Torres Strait Islander ☐

Other Cultural Background:

Country of Birth:

Please notify us promptly of any changes to your contact details.

MEDICAL HISTORY

Height | Weight | Blood type

Alcohol intake:

Non-drinker ☐ Days per week | Standard drinks per day

Smoking status:

Non-smoker ☐ Ex-smoker ☐ Current smoker ☐

Medical Condition(s):

Regular Medications and Doses:

Allergies/Adverse Reactions:

CONSENT

Our Practice uses a reminder system to help maintain your health. The reminders are sent by post, telephone, or SMS.

I consent to being contacted with reminders.

Yes ☐ No ☐

Our Practice sends information to the Australian Immunisation Register and National Cancer Screening Registry. These registers also send reminders, which can be helpful if you move.

I consent to my information being sent to these registers.

Yes ☐ No ☐

Our practice also sends information to My Health Record.

I consent to my information being sent to My Health Record.

Yes ☐ No ☐

Patient / Guardian Signature

Date