Patient surname: Patient DOB:

New Patient Registration Form (if HotDoc New Patient Form unfilled)

Title please tick or write

Mr		Mstr		Mrs		Ms		Miss		Mx		Other:	

First name:	**Last name:**
Preferred name:	**Date of birth:**

Sex at birth please tick or write

Female		Male		Other:	

Gender please tick or write

Prefer not to answer		Female		Male		Non-binary		Other:	

Pronouns please tick

she/her/hers		he/him/his		they/them/theirs	

Phone number:

Do you consent to receive SMS reminders, messages and emails please tick

Yes		No	

Email address:

Residential address (must not be a PO Box):

Street			
Town/Suburb			
State		Postcode	

Postal address (if different to residential address)**:**

Street			
Town/Suburb			
State		Postcode	

Medicare details (if applicable)**:**

Number	_ _ _ _ _ _ _ _ _ _	IRN (number next to your name)		Expiry	

Pension or Health Care Card details (if applicable)**:**

Number	_ _ _ _ _ _ _ _ _	Expiry	

Patient surname: Patient DOB:

DVA details (if applicable)**:**

Number	_ _ _ _ _ _ _ _ _	Expiry		Gold		White	

	Next of Kin	**Emergency Contact** (tick box if same)	
Name			☐
Phone number			
Relationship to you			

Do you identify as

- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Both Aboriginal and Torres Strait Islander
- ☐ Neither

What is your ethnicity?

- ☐ Caucasian
- ☐ European
- ☐ African
- ☐ Oceanian
- ☐ Asian
- ☐ Other (please specify):
- ☐ Australian Aboriginal
- ☐ Torres Strait Islander
- ☐ North American
- ☐ South American

Country of birth:

Occupation:

Is English your first language?

- ☐ Yes
- ☐ No → Do you require an interpreter?
  - ☐ No
  - ☐ Yes → Please specify the language:

Do you have any allergies **or are you sensitive to any medications or dressings?**

- ☐ No
- ☐ Yes → Please list what the allergen is and the reaction. If more room is required, please use the back page.

_____

_____

_____

_____

Do you smoke tobacco?

- ☐ Never smoked
- ☐ Ex smoker:
  - Frequency of smoking (please circle): Daily / Weekly / Less than weekly
  - Average number of cigarettes smoked on a usual smoking day:
  - What year did you commence smoking:
  - Duration of smoking in years:
- ☐ Current smoker:
  - Frequency of smoking (please circle): Daily / Weekly / Less than weekly
  - Average number of cigarettes smoked on a usual smoking day:
  - What year did you commence smoking:

Patient surname: Patient DOB:

Do you vape?

- ☐ Never vaped
- ☐ Ex vaper
  - Frequency of vaping (please circle): Daily / Weekly / Less than weekly
  - Average number of puffs per day on a usual vaping day:
  - What year did you commence vaping:
  - Duration of vaping in years:
- ☐ Current vaper
  - Frequency of vaping (please circle): Daily / Weekly / Less than weekly
  - Average number of puffs per day on a usual vaping day:
  - What year did you commence vaping:

Do you drink alcohol?

- ☐ No
- ☐ Yes

How often do you have a drink containing alcohol?

- ☐ Monthly or less
- ☐ 2-4 times a month
- ☐ 2-3 times a week
- ☐ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?

- ☐ 1 or 2
- ☐ 3 or 4
- ☐ 5 or 6
- ☐ 7 to 9
- ☐ 10 or more

How often do you have six or more drinks on one occasion?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

Privacy and Terms

We are committed to protecting the confidentiality of your personal information and health records.
In submitting this form, you;

1. acknowledge that we, and our service providers, will collect your personal and health information to enable us to provide you with our health services and any related communications (for example, to manage your appointment bookings)
2. consent to our handling of your personal information in accordance with our Privacy Policy (you can access our Privacy Policy on our website, or by asking us for a copy)
3. agree to abide by the practice policies, including, but not limited to, the billing and failure to attend policies and the Zero Tolerance Behaviour Policy

I agree to the terms listed above.

Signature: **Date:**