

# HEAL MEDICAL CENTRE

## New Patient History

*Welcome to Heal Medical Centre*

Mr, Mrs, Ms, Miss, Mast: \_\_\_\_\_  
(Please circle)

Address: \_\_\_\_\_

Home No: \_\_\_\_\_ Mobile No: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you **Aboriginal** or **Torres Strait Islander**?

No / Yes, Aboriginal / Yes, Torres Strait Islander / Yes, Both

(Please circle)

Nationality: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Do you have any known allergies? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ if yes, how many a day? \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone No: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone No: \_\_\_\_\_

(If as above, please leave blank)

Medicare No: \_ \_ \_ \_ \_ Position on card: \_\_\_\_ Expiry: \_\_\_\_\_

Pension or HCC No: \_\_\_\_\_ Expiry: \_\_\_\_\_