

PLEASE FILL THIS OUT AND **RETURN PRIOR TO YOUR APPOINTMENT**
NEW PATIENT OR UPDATED Patient INFORMATION for Mr Makris / McClatchey:

Have you seen Mr McClatchey or Mr Makris in the past?

Mr / Mrs / Miss / Ms / Master Date of Birth :.....

FIRST NAME(S)..... **SURNAME:**

Postal Address:.....

.....

PHONE: Home..... Work..... Mobile.....

Email address (if you have one):

Next of Kin (or Emergency Contact): Name: _____ Ph: _____

Is above contact a relative or friend – please state relationship: _____

MEDICARE NUMBER: _____ / REF _____ Expiry ____/____

Do you have: **PRIVATE HEALTH INSURANCE** for Hospital: **Yes / No**

Health Fund Name..... **Membership** Number:.....

Usual GP (if different from referring doctor):.....

Are you on any of the following Concession Cards – if so please fill out or if not cross out:

PENSION CARE CARD? NUMBER..... Expiry:

Health Care Card? NUMBER..... Expiry:

Veteran Affairs Card NUMBER..... Card colour

ANY ALLERGIES TO MEDICATIONS:.....

Allergy to? Shell Fish - YES / NO OR Iodine - YES / NO

Diabetic: YES / NO - if YES Diet Controlled or Medications?

On any blood thinning medication such as Astrix/Aspirin/Warfarin :

Please list all medications you currently take – including: Name of drug / Dosage eg Mg / How often taken

