Square Medical Centre
New Patient Registration Form

P: 9777 0024
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644 George St, Sydney
NSW 2000

| **Patient Information** | | Title Mr/Mrs/Miss/Ms | Male / Female |
|---|---|---|---|
| Surname | Given Name | Date of Birth | |
| Street Address | | | |
| Suburb | State | Postcode | |
| Home Phone | Mobile | Work Phone | |
| Marital Status | Occupation | Country of Birth | |
| Are you an Aboriginal or Torres Strait Islander? | | Other Languages Spoken | |
| Email address | | Would you like to sign up to our mailing list? Yes No | |
| **Emergency Contact Information** | | | |
| Name | Relationship | Contact Number | |
| **Medicare Details** | | | |
| Medicare Number | | Number on Card | Expiry |
| **Concession Card Details** | | | |
| Concession Card Number | | Type of Concession | Expiry |
| **Medical Information** | | | |
| Allergies □ Nil Known<br>_____<br>_____<br>_____<br>_____ | | Family History (cancers, diabetes, heart disease, etc)<br>_____<br>_____<br>_____<br>_____ | |
| Current Medication(s) □ No Regular Medication<br>_____<br>_____<br>_____<br>_____ | | Medical History (current and past)<br>_____ □ No significant history<br>_____<br>_____<br>_____ | |
| Do you smoke? Yes No<br>If yes, how many cigarettes per day?<br>Ex Smoker □ Year Stopped: | | Do you drink alcohol? Yes No<br>How many days per week?<br>How many glasses per day? | |

Patient/Guardian Signature: Date:

I consent to Square Medical Centre collecting, sharing and receiving information about my OR my child's medical records with other health professionals in relation to my complete medical care. A full privacy policy is available from reception in regards to how we manage and protect your health information.