# OCEAN MEDICAL PRACTICE

**NEW PATIENT REGISTRATION FORM**

| | |
|---|---|
| Title: | ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr |
| Surname | |
| First Name/s | |
| Date of Birth | / / |
| Street Address | Postcode: |
| Postal Address (if different) | Postcode |

| | | | |
|---|---|---|---|
| ☐Home: ☐ Mobile ☐ Work | | | |
| Email | | | |
| Medicare No | Ref: | Expiry Date | |
| DVA Gold/White | | Expiry Date | |
| Pension/HCC | | Expiry Date | |
| AHM/OSHC | | Expiry Date | |
| Next of Kin | Name: Relationship:<br>Address:<br>Contact number: | | |
| Emergency Contact (if different) | | | |

| | |
|---|---|
| Are you Aboriginal or Torres Strait Islander? ☐ Aboriginal ☐ Torres Strait Islander ☐ No | |
| Ongoing Medical Issues: | Regular Medications: |
| Significant Past Medical Issues/Surgery: | Allergies:<br>Smoker: ☐Yes ☐ No |
| Family History: ☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Cancer (Please Specify…….)<br>☐ Other: …… | |

Signature: …….....…. Date: ..... / ..... / .....