# Kew Medical

MEDICAL · COSMETIC · WELLNESS

# New Patient Registration

**PERSONAL DETAILS**

| | | | |
|---|---|---|---|
| TITLE | Mr / Mrs / Dr / Ms / Miss / Master | GENDER | ☐ Male ☐ Female |
| GIVEN NAME | | SURNAME | |
| DOB | / / | COUNTRY OF BIRTH | |
| MARITAL STATUS | | OCCUPATION | |

Are you of Aboriginal / Torres Strait Islander descent? ☐ YES ☐ NO

Do you consume alcohol? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO

Do you have any allergies? ☐ YES ☐ NO
if YES, please specify:

**CONTACT DETAILS**

RESIDENTIAL ADDRESS

| | | | |
|---|---|---|---|
| STATE | | POSTCODE | |

POSTAL ADDRESS (if different from above)

| | | | |
|---|---|---|---|
| PHONE (H) | | (M) | |
| EMAIL | | Preferred method of contact: | |

Do you consent to receive messages from our practice's SMS reminder system? ☐ YES ☐ NO

176 COTHAM ROAD
KEW, VIC 3101

KEWMEDICAL.COM.AU
(03) 9817 7071

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**EMERGENCY CONTACTS / NEXT OF KIN** (Please provide two contacts)

CONTACT 1

| FULL NAME | RELATIONSHIP |
| --- | --- |
| ADDRESS | PHONE |

CONTACT 2

| FULL NAME | RELATIONSHIP |
| --- | --- |
| ADDRESS | PHONE |

**HEALTH COVER DETAILS** (Please tick and provide details as applicable)

| | | |
| --- | --- | --- |
| ☐ MEDICARE # | Line # | Expiry / |
| ☐ PENSION CARD # | | Expiry / |
| ☐ HEALTHCARE CARD # | | Expiry / |
| ☐ DVA CARD # | Colour | Expiry / |
| ☐ PRIVATE HEALTH FUND | | Line # |
| ☐ WORKCOVER / TAC ACCOUNT | | Claim # |