Maranoa Medical Centre
27 Quintin Street, Roma QLD 4455
Phone (07)4622 2266 Fax (07)4622 8969

~MMC~

NEW PATIENT INFORMATION FORM

MR/MRS/MISS/MS/Other:_____ Surname: _____

Given names: _____ Preferred name: _____

Date of Birth: _____/_____/_____ Gender: Male / Female

Ethnicity: _____ Do you identify as Aboriginal / Torres Strait Islander? (Please circle)

Residential Address: _____

Postal Address (if different): _____

Contact number: Mobile: _____ Home: _____ Work: _____

Consent to receive SMS appointment reminder: YES / NO Consent to upload to My Health record: YES / NO

Medicare Card Number: _____ Ref No: ____ Expiry Date: _____

Concession Card (if applicable): Health Care Card / Pensioner Card / DVA Card? (Please circle)

Card Number: _____ Expiry Date: _____

Next of Kin: _____ Relationship: _____ Contact No: _____

Next of Kin's Address: _____

Emergency Contact (if unable to contact NOK):_____ Contact No:_____

Occupation: _____ Employer/School: _____

Private Health Cover: Yes / No Medical Insurance Cover: Yes / No

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Medical History

Allergy	Reaction	Severity (Please circle)
		Mild / Moderate / Severe
		Mild / Moderate / Severe
		Mild / Moderate / Severe

Smoking Status (Please circle): SMOKER / EX-SMOKER / NON-SMOKER Date Started:_____ Date Stopped:_____

How many days a week do you drink alcohol? _____ Number of drinks on each occasion: _____

Do you wish to be part of our mailing reminder system for cervical screening/pap smear, immunisations, etc: Yes / No

If applicable, when was your last pap smear/cervical screening test? _____

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