EASTGATE
MEDICAL

NEW PATIENT REGISTRATION FORM	
Name:	DOB:
	PPSN:
	Gender: Male ☐ Female ☐ Other ☐
Mobile:	Home Tel:
Email:	
Address:	
Next of kin: Name:	Tel. Number:
Name/address of previous GP:	
Medical Card (GMS) or Doctor Visit Card? Yes No	GMS or DVC number:
What GP is your card currently registered with?	
Private Health Insurance? Yes No	Provider/Policy number:
History of medical problems:	
Current list of medications:	
Do you have any allergies? Yes No	
Consent to receive text messages regarding results/appointments? Yes No	
Signed:	
Date:	