We are committed to providing our patients with the best care.

To do this, it is essential that your Personal Information is up to date & accurate.

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| Title (please circle): Miss Mrs Ms Mr Master Dr Prof |
| First Name: Surname: |
| Date of Birth: Country of Birth: |
| Medicare Card Number (10 digits): Ref No.:  Card Expiry Date:  Concession card or Pension card number: Expiry: |
| Address: Suburb: |
| Home Phone Number: Mobile Number: |
| Work Phone Number: Email Address: |
| Marital Status: Occupation: |
| Preferred Method of Contact (please circle) : Home Work Mobile Email |
| Are you allergic or sensitive to any medications: Yes No  Please specify: |
| **Next of Kin: (Only in case of an emergency please provide full details)** |
| FULL NAME: Relationship to Patient: |
| Address: Phone Number: |
| **History** |
| Do you smoke? No Yes Number per day:  Have you smoked previously? No Yes  Do you drink alcohol? No Yes Number per day:  Do you take illicit drugs? No Yes |
| **Do you suffer from any of the following conditions?** (please circle)  Asthma Diabetes Hypertension  Mental Illness Heart Disease Chronic Illness  Cancer |
| **Are you currently taking any medications? Please specify:** |
| **How did you hear about our clinic?** (Please circle)  Passing by Building Internet Hot Doc Friend/Family White Pages |
| **Do you require an Interpreter Service Yes No Language:** |
| **Do you identify as being:** Aboriginal Yes No  Torres Strait Islander Yes No  Other Cultural Group Yes No  None Please circle |
| **Reminder Messages:** Do you consent to text message reminders? **YES NO** |
| **My Health Record:** Do you consent to having your data shared with My Health Record? **YES NO** |

Our practice provides our patients with preventative care and early case detection reminders EG: Immunisation, annual health checks, skin checks and cervical screening.

Patient Signature (or Patient/Guardian if patient is a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_