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 NoPlease 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 YesDo 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 IllnessCancer |
| **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: \_\_\_\_\_\_\_\_\_\_