PATIENT INFORMATION FORM

We are committed to providing our patients the best care. To do this it is essential that your health record is kept up to date and accurate.

Could you please assist us by completing the following:

TITLE Mr Mrs Ms Miss Dr	
LAST NAME	
FIRST NAME	
MIDDLE NAME	
PREFERRED NAME	
DATE OF BIRTH	
SEX (MALE,FEMALE) NOT COMPULSARY	
ETHNICITY **COUNTRY OF BIRTH**	
ARE YOU ABORIGINAL OR **TORRENS STRAIGHT ISLANDER ORIGIN?**	
ADDRESS (HOME)	
ADDRESS (POSTAL)	
HOME PHONE	
WORK PHONE	
MOBILE PHONE	
EMAIL	

PATIENT INFORMATION FORM

MEDICARE NUMBER	
MEDICARE REFERENCE NO. (Number next to name) **& EXPIRY DATE**	
DO YOU CONSENT TO SMS'S FOR REMINDERS	
ARE YOU REGISTERED FOR E-HEALTH	
PENSION/HEALTH CARE CARD NUMBER AND EXPIRY DATE	
DVA NUMBER	
PRIVATE HEALTH FUND AND MEMBER NUMBER	
NEXT OF KIN: **RELATIONSHIP TO YOU:** **PHONE NUMBER:** **ADDRESS:**	
EMERGENCY CONTACT: **RELATIONSHIP TO YOU:** **PHONE NUMBER:** **ADDRESS:**	
CURRENT OCCUPATION **(IF RETIRED PREVIOUS OCCUPATION)**	
MARITAL STATUS	

PATIENT INFORMATION FORM

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care & management.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

I consent to SMS for reminders and results being sent & will inform staff if the mobile is a 'shared' phone.

Patient's name: …………………………………………………………… Date: ………………..

Patient's signature: …………………………………………………………..

OR

Signed as Guardian for child: ……………………………………………

PATIENT INFORMATION FORM

Please list all medications taken by you including dosages.
Please list any vitamins or complimentary medications taken by you.
Do you have any allergies? If so, please list allergies and the nature and severity of your reaction.
Do you smoke cigarettes? If so how many do you smoke per day? How old were you when you started smoking?
Have you smoked in the past? If so, how many cigarettes did you smoke per day? How old were you when you started smoking? How old were you when you stopped smoking?

PATIENT INFORMATION FORM

Do you consume alcohol?

If so how many days per weeh/month/year do you consume alcohol?

On the days you consume alcohol, how many standard glasses of alcohol do you consume?

Please list any past illnesses including operations.

Please list any current medical problems.

Do you do any regular exercise?

If so please provide details.

PATIENT INFORMATION FORM

Do you have a family history of any illness including heart problems, stoke, diabetes, high blood pressure, cholesterol problems or cancer?

Please provide details including which family member, age of onset and age of death (if applicable).

Please provide details of all immunisations.

For children please bring a copy of the “blue book” so all immunisations can be entered in to our data base.