

Patient Detail Form (please complete both sides)

<input type="checkbox"/> Mr	<input type="checkbox"/> Master	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	<input type="checkbox"/> Miss	<input type="checkbox"/> Other
Surname: _____		Given Name: _____		Middle Name: _____	
Date of Birth: ____ / ____ / ____ : Ethnicity: (other than Australian) _____					
<input type="checkbox"/> Australian	<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander	Occupation:		
Street Address: _____ City/Suburb: _____ Postcode: _____					
Home Phone: _____		Mobile: _____		Work Phone: _____ E-mail: _____	
Medicare Number: _____		Ref No: (Next to Name) _____		Expiry Date: (Bottom Right Corner) _____	
How would you like your reminders sent: <input type="checkbox"/> Phone / Mobile <input type="checkbox"/> Post <input type="checkbox"/> SMS					
<input type="checkbox"/> Health Care Card No: _____ Expiry Date: _____ <input type="checkbox"/> Pension Card No: _____ Expiry Date: _____ <input type="checkbox"/> Department of Veteran Affairs Card Number: _____ Expiry Date: _____ Health Insurance Fund: _____ Membership No: _____					
EMERGENCY CONTACT: I authorise the following person to be contacted in the case of an emergency:					
Name: _____		Relationship: _____		Contact No: _____	
NEXT OF KIN:					
Name: _____		Relationship: _____		Contact No: _____	
Family: <input type="checkbox"/> Unknown (eg Adopted) <input type="checkbox"/> No Significant Family History					
Mother Alive <input type="checkbox"/> Yes <input type="checkbox"/> No		Age of Death: _____		Cause of Death _____	
Father Alive <input type="checkbox"/> Yes <input type="checkbox"/> No		Age of Death: _____		Cause of Death _____	
Significant Family History:					
Mother: <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Depression <input type="checkbox"/> Breast Cancer					
Father: <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Depression					
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> De Facto Elite Athlete <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Feeding <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you have any allergies: <input type="checkbox"/> Yes (Please List) <input type="checkbox"/> No _____		
Do you use any of the following: Past Alcohol Intake: <input type="checkbox"/> Nil <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy					
Alcohol <input type="checkbox"/> No. <input type="checkbox"/> Yes Days per week _____ Standard drinks per day _____ Year Started: _____ Year Stopped: _____					
Smoker <input type="checkbox"/> No. <input type="checkbox"/> Yes How many per day _____ Year Started _____ <input type="checkbox"/> Ex-Smoker Ceased: _____					
How did you get to know about us? <input type="checkbox"/> Google <input type="checkbox"/> Website <input type="checkbox"/> Facebook <input type="checkbox"/> Health Engine/HotDocs					
<input type="checkbox"/> Letterbox/Leaflet/Magnet <input type="checkbox"/> Walk In <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Chemist					
<input type="checkbox"/> Other.....					

PLEASE SIGN ON REVERSE SIDE
 Driver's License Sighted

Privacy Statement

Your Personal Health Information and your Medical Records may be collected, used and disclosed, including but not limited to the following reasons:

- For Communicating relevant information with other treating doctors, specialists or allied health professionals
- For follow up reminders/recall notices
- For disease notification as required by law (e.g. infectious diseases)
- For use by all doctors in this practice, when consulting with you
- For research purposes (de-identified, meaning you are not able to be identified from the information given)
- For obtaining previous pathology and radiology results.
- For Uploading Information onto your personal 'My health Record'.

If you have any concerns or wish to restrict access to your personal health information, please discuss these with your doctor.

Signature: _____

Date: _____