Family Medical Practice

Est. 1975

This information is private and confidential and is for use in your clinical file only

Please provide as much detail as possible to assist us with providing quality care.

Full name: Mr/ Mrs/ Ms/ Miss/ Dr **Surname:** _____

Given Name/s: _____

Date of Birth ___/____/_____

Ethnicity: Aboriginal or TSI **Other** :_____

Medicare or Veterans Affairs No._____

Reference No. (next to your name) :_____ **Expiry:**_____

Pension/Healthcare Card No._____ **Expiry:** _____

Do you have private health fund? Yes / No **Fund** _____

Number _____

Your Home Address: _____

Postal Address: (if different to home) _____

Suburb: _____ **Postcode:** _____

Phone: _____ **Mobile:** _____ **Work:**_____

Do we have permission to contact you at work? Yes / No

Next of Kin/Emergency Contact Person

Name: _____ **Relationship:** _____

Phone :_____ **Mobile:** _____

Please list any known allergies and your reactions or leave blank if you have no allergies:

_____

Please list any other information you would like included in your health record:

_____

Marital Status: Single / Married / De-facto / Divorced / Widowed / Separated

Do you have a Carer: Yes / No **If Yes, Carer Name:**_____
Contact No: _____

Do you have or have you had any of the following?:

Diabetes Kidney Disease Asthma High Blood Pressure Heart Problems

Breast Cancer Colon Cancer Stroke Depression Epilepsy Other Cancer

Family History – Leave blank if there is no significant history

Mother: Still alive: Yes / No **If no, age at Death:** _____

Diabetes Kidney Disease Asthma High Blood Pressure Heart Problems

Breast Cancer Colon Cancer Stroke Depression Epilepsy Other Cancer

Father: Still alive: Yes / No **If no, age at Death:** _____

Diabetes Kidney Disease Asthma High Blood Pressure Heart Problems

Breast Cancer Colon Cancer Stroke Depression Epilepsy Other Cancer

Yours or other immediate family members' significant illness:

_____

Do you know your blood group? Yes / No **Group:** _____

By providing the above details to Family Medical Practice and signing this form I agree and consent to the following:

I consent to the use of my personal health information by Family Medical Practice and other health care providers involved in my medical treatment and health care within this practice.

I consent to the disclosure of my personal health information by the above named practice to other health care providers involved directly or indirectly involved in my personal health care or medical treatment.

As part of preventative health services offered by this practice (mail out of follow up reminders and recalls when routine investigations are due), I consent to receive follow up reminders and recalls to be sent to the address I have listed above.

Printed Name _____

Signature_____

Date_____/_____/_____

****PLEASE NOTE: IF YOUR DETAILS CHANGE IN THE FUTURE,***

IT IS YOUR RESPONSIBILITY TO NOTIFY STAFF TO UPDATE YOUR RECORDS*