The Health Care Centre
PROVIDING MEDICAL AND ALLIED HEALTH CARE
17 Kialla Road Crookwell 2583

PATIENT DETAILS FORM

Please complete the following information and return to our reception staff

Mr/Mrs/Miss/Ms/Mast/Other: _____ Family Name: _____ Given Name: _____

Middle Name: _____ Preferred Name: _____ Date of Birth_____

Sex: ☐ M ☐ F: ☐ OTHER:_____ Religion: _____ Occupation: _____

Ethnicity:

1. ☐ Australian, non-indigenous **2**. ☐ Aboriginal but not Torres Strait Islander: **3.** ☐ Torres Strait Islander but not Aboriginal: **4.** ☐ Both Aboriginal and Torres Strait Islander. **If you ticked 2, 3 or 4 -** Are you registered for Closing The Gap? – (The Program applies to prescriptions for PBS General Schedule medicines only). ☐ Yes ☐ No If **No** would you like us to register your name for this program? ☐ Yes ☐ No

☐ **5.Other** (Please specify) _____

Country of Birth: _____

Residential Address: _____

Postal Address (if different from above):_____

Phone Numbers: Home: _____ Work: _____ Mobile:_____

Preferred contact number: ☐ Home ☐ Work ☐ Mobile

Email address: _____

Medicare Number: _____ Position on card: _____ Expiry Date: _____

Person listed as number 1 on your Medicare Card: _____

Concession Cards: ☐ Health Care Card ☐ Pension Card ☐ C'Wealth Senior's Card ☐ DVA Card

Card number: _____ Expiry: _____

Private Health Insurance: Fund Name_____ Policy Number_____

Usual Doctor: ☐ Heidi Ehmann ☐ Johanna Kovats ☐ Rebecca Scott ☐ Jenna Iwasenko

☐ Clare Patterson ☐ Abedin Al Jannati ☐ Kabita Gautam

<u>Next Of Kin Details</u>

Name: _____ Address: _____

Phone No: _____ Alternate Phone No: _____ Relationship: _____

<u>Emergency Contact Details</u> Or tick to use Next of Kin details ☐

Name: _____ Address:_____

Phone No: _____ Alternate Phone No: _____ Relationship: _____

→ → → → *PTO to complete information*

HOW WOULD YOU LIKE THE PRACTICE TO COMMUNICATE WITH YOU?

(a)Would you like to receive test results via Email? ☐ Yes ☐ No (Please bear in mind that the email address supplied should be private to you and information contained in the email may also be compromised if it is not secure).

(b)Do you consent to SMS appointment reminders and clinical recalls? ☐ Yes ☐ No

(c)If you are unable to receive SMS appointment reminders, do you give permission for an appointment confirmation message to be left at your household? ☐ Yes ☐ No

(d) Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone or SMS for procedures such as vaccinations, Pap tests and other health reviews
I consent to being contacted with reminders to help me maintain my health ☐ Yes ☐ No

(e)Do you give permission for information to be given to other health care providers e.g. hospital, specialist doctor, podiatrist, psychologist, pharmacist in the course of your care? This information may be sent via email. ☐ Yes ☐ No

(f) Research – Do you give consent to disclosure for research and quality activities to improve individual community health care and Practice Management. (This may occur when the Practice incorporates patient health records into de-identifiable patient information to transfer to a third party, normally used for quality improvement projects. De-identifiable patient information cannot be traced back to the individual.)Declining to participate in research will not affect the care you receive at this practice.

☐ Yes ☐ No

(g)Do you require the services of a language interpreter? ☐ Yes ☐ No

(h)Do you require assistance with reading or understanding medical terminology? ☐ Yes ☐ No

ABOUT YOUR HEALTH

Do you have any of the special needs listed below?

Hearing impairment ☐ Yes ☐ No

Vision impairment ☐ Yes ☐ No

Physical impairment ☐ Yes ☐ No

Other ☐ Yes Please advise: _____

Allergies

☐ Nil known allergies

List allergies or reactions to medications	Describe your reaction

Signed_____ **Dated**_____

Office Use Only											
Entered	Date	Initial	Checked	Date	Initial	Scanned	Date	Initial	Nurse	Date	Initial