******

**PATIENT DETAILS FORM**

**DATE: / /**

***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 No: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ / \_\_ 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: - \_\_\_ /\_\_\_ /\_\_\_\_\_\_ (Please present card to receptionist)

Private Health Insurance: Fund Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Usual Doctor: □ Dr. Heidi Ehmann □ Dr. Johanna Kovats □ Dr. Rebecca Scott □ Dr. Jenna Iwasenko

□ Dr. Manjari Bhuwan □ Dr. Jackie Naluyimbazi □ Dr. Elias Nasser

**Next Of Kin Details**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Details Or tick to use Next of Kin details** □

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

→ → → → PTO to complete information

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Office Use Only | | | | | | | | | | | |
| Entered | Date | Intitial | Checked | Date | Initial | Scanned | Date | Initial | Nurse | Date | Initial |
|  |  |  |  |  |  |  |  |

**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 require the services of a language interpreter? □ Yes □ No**

**(f)Do you require assistance with reading or understanding medical terminology? □ Yes □ No**

**(g)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**

**(h) 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**

**ABOUT YOUR HEALTH**

**Do you have any of the special needs listed below?**

Hearing impairment □ Yes

Vision impairment □ Yes

Physical impairment □ Yes

Other □ Yes Please advise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies and medicines**

List allergies or reactions to medications Describe your reaction

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_ / \_\_\_ / \_\_\_