



# PATIENT INFORMATION

Mr  Mrs  Ms  Miss  Mast  Dr

DR \_\_\_\_\_ Date \_\_\_\_\_

Surname: \_\_\_\_\_ FirstName: \_\_\_\_\_

Date of Birth:    /    /

Postal Address: \_\_\_\_\_ Town: \_\_\_\_\_ Postcode: \_\_\_\_\_

Street Address (if different from Postal): \_\_\_\_\_

Day Time Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email address:

Next of kin Name & address:

Relationship to you:

Contact phone number (mobile):

Home:

Emergency Contact Person:

Relationship to you:

Contact phone number (mobile):

Home:

Your cultural identity:

Aboriginal  Torres Strait Islander  Non Indigenous  Other \_\_\_\_\_

Medicare Number

Ref No. Next to name:  Expiry: \_\_\_/\_\_\_/\_\_\_

Concession Card Number (Pensioner or Health Care Card)

Expiry: \_\_\_/\_\_\_/\_\_\_

DVA Card Number

DVA Gold  or White Card  Expiry: \_\_\_/\_\_\_/\_\_\_

**Dependent Children/Other Family Members**

Name	Date of birth	Name	Date of birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## FEEDBACK

How did you find out about our Medical Centre(s)?

Word of Mouth     White Pages     Yellow Pages     Signage outside practice  
 Drive / Walked past     Internet     Newsletter     Friends  
 Pharmacy     Other (please specify) \_\_\_\_\_

**PLEASE TURN OVER AND COMPLETE HEALTH SUMMARY**

Do you have any on-going health problems? YES  NO

If yes, please list

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Have you had any significant previous health problems? YES  NO

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**Have you ever had or family history of**

- Diabetes  Mother  Father  Brother/Sister  Grandparent  No
- Heart disease  Mother  Father  Brother/Sister  Grandparent  No
- Stroke  Mother  Father  Brother/Sister  Grandparent  No
- Asthma  Mother  Father  Brother/Sister  Grandparent  No
- Cancer  Mother  Father  Brother/Sister  Grandparent  No

If yes to cancer question, please specify what kind: \_\_\_\_\_

Please list all medications you currently take; None

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Please list any drug, food or other allergies you have; Nil known

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**Do you smoke?**

- No  If you are an ex-smoker , when did you stop? .....
- Yes  How many per day? .....

**Do you consume alcohol?**

- No
- Yes  How many standard drinks per day..... Week.....
- Occasionally

**Do you take any other recreational substances?**

- No
- Yes  Please detail.....
- Occasionally

**When did you last have these immunizations?**

- Influenza Date;
- Pneumonia Date;
- Tetanus Date;

**Women's Health**

**When was your last Pap smear?**

- Date if known.....
- Within last 12 months
- Within last 2 years
- More than 2 years ago
- More than 4 years ago
- Never
- Not required

**Men's Health – if over age 45**

**When was your last Prostate check?**

- Date if known.....
- Within last 12 months
- Within last 2 years
- More than 2 years ago
- More than 4 years ago
- Never

**Office use only**

Date entered \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Name



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

Korumburra Medical Centres collect 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 Australia 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.
- To contact you or your family for the purposes of Recalls & Reminders

Patient information shall not be released to a third party without the expressed consent of the patient.

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I have read the information above and understand the reasons why my information is collected.

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.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Name: \_\_\_\_\_

I also consent to receiving SMN (secure Message Notification) for both appointments and recall/reminders. \_\_\_\_\_ Signature