Patient Information Form

Please complete and give **page 1 and 2 to reception** and take **pages 3 and 4 into the consultation** with you.

Personal Contact Details (Name as it appears on your Medicare Card)

Title (Please circle): **Mr Mrs Ms Miss Mast Other** (please specify): _____

Family/Last Name: _____

Given Names: _____ **Preferred Name:** _____

Date of Birth: Day _____Month _____ Year _____

Birth Sex (Please circle)**:** Male/ Female/ Other

Gender Identity: Male/ Female/ Non-binary/ Gender diverse/ Transgender/ Different identity

Pronouns : She/Her/Hers He/Him/His They/Them/Theirs

Home Address: _____

_____ **Postcode:** _____

Postal Address: _____

_____ **Postcode:** _____

Home phone number: _____ **Mobile Number:** _____

Work phone number: _____ **Email:** _____

Ethnicity (Please circle)

Australian, non indigenous **Aboriginal but not Torres Strait Islander**

Torres Strait Islander but not Aboriginal **Both Aboriginal and Torres Strait Islander**

Other **Country of Birth:** _____

Government Identifiers

Medicare Card No.: _____ **IRN :** _____ **Expiry Date:** _____

Concession Card Number: _____ **Expiry Date:** _____

Pension Card / Health Care Card / DVA Gold / /DVA White (state conditions below)

DVA White card conditions _____

Patient Information Form

Next of Kin

Name: _____

Address: _____

Phone/Mobile Number: _____

Relationship to Patient: _____

Emergency Contact Details (if different from Next of Kin)

Name: _____

Address: _____

Phone/Mobile Number: _____

Relationship to Patient: _____

Do you consent to be contacted via SMS for appointment reminders, recall and other text reminders or medical services we offer?: Y / N

Important Information

Transfer of medical records: If you have previously seen a GP at another medical practice the information held by that GP may assist us with your future healthcare needs. If you wish to have your records transferred to this surgery please advise reception.

MSMC operate a recall and reminder system. Recall – you will be contacted by reception if your doctor would like a follow-up appointment to discuss radiology/pathology test results. Reminder – when you are due for routine preventative health measures such as cervical screening, vaccinations, health checks etc you will be contacted and advised to make an appointment.

Doctors at Main Street Medical Centre on occasions are asked to participate in research for quality assurance. To enable them to do this they need permission to use de-identified medical information from the patient's medical records. This form covers the collection and use of your information to provide comprehensive, co-ordinated and continuing whole person medical care. The privacy policy outlines the way that your information may be disclosed to other health care professionals to provide this high level of care.

MSMC are committed to maintaining the confidentiality of your personal information. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised member of staff. A copy of the Practice Privacy Policy is available at reception.

Please sign this form as confirmation that you have read and understood our privacy policy, and consent to the use of your health information in the manner described above.

Signature: _____ **Name:** _____ **Date:** _____

Please hand pages 1 and 2 to RECEPTION before completing pages 3 and 4
We can then add your details into the computer and let your doctor know you have arrived

Patient Information Form

Information for your doctor

Patient Name : _____

Height: _____ **cm** **Weight:** _____ **kg**

Occupation: _____

Children's immunisations

If completing this form for a child are their immunisations up to date? Y / N

Social History

Marital Status

Single / Married / De facto / Widowed / Divorced

Allergies

Do you have any allergies or are you sensitive to drugs or dressings

Y / N (if yes please list) _____

Do you smoke?:

Never smoked / Ex smoker (date quit) _____ / Smoker (no. per day) _____

Days a week you drink alcohol: Never / Daily / 1-2 Days / 3-4 Days / 5-6 Days / Every Day

How many standard drinks per occasion? _____

Drug Use: (type and frequency) _____

Medical History

Current or past medical conditions:

Asthma	Y / N	Diabetes	Y / N	Hypertension	Y / N
Epilepsy	Y / N	Depression	Y / N	Migraine	Y / N
High Cholesterol	Y / N	Blood Pressure	Y / N	Kidney Disease	Y / N
Cancer	Y / N	Arthritis	Y / N	Blood Disorders	Y / N

Other (please specify): _____

Patient Information Form

Have you had any operations? (Please give details)

_____

Current Medications

_____

_____

Family History

Have any members of your family had (if yes please specify which relative)

Asthma Y / N _____ Diabetes Y / N _____

Heart Disease Y / N _____ Mental Illness Y / N _____

Cancer Y / N _____

Females

When did you last have?

Pap smear: Date _____ / Not sure / Never

Breast check: Date _____ / Not sure / Never

Males

When did you last have?

An overall check up: Date _____ / Not sure / Never