UNION STREET FAMILY MEDICAL PRACTICE

PATIENT INFORMATION

Please fill out the following details, taking care to record your name as it appears on your Medicare Card.
The information you provide to us is confidential. It is used to correctly identify you within the Practice, in our dealings with Medicare and with other health professionals who are involved in your care. Thank you.

MR/MRS/MS/MISS/MST/MX GIVEN NAME: .....**SURNAME:** .....

PREFERRED NAME: ..... **DOB**: ..... **EMAIL**: .....

MEDICARE CARD: ..... Ref No: ..... Exp Date: .....

PENSION NUMBER: ..... Expiry Date: ..... Type: .....

Please tick your cultural background: ☐ Aboriginal origin ☐ Torres Strait Islander origin ☐ Neither ☐ Other cultural background ……

Country of Birth: …… Primary Language: .....……

ADDRESS:……..

PHONE NO: (Home) …… (Work) ……

MOBILE: …… OCCUPATION ……...

MARITIAL STATUS: Married / De-facto / Divorced / Separated / Single /Widowed / Other …….

NEXT OF KIN: NAME: ……..…… D.O.B. …….

RELATIONSHIP TO YOU: (i.e. Mother/father/Partner etc) …….

PHONE NO: …… OCCUPATION: …….....

EMERGENCY CONTACT: NAME: …….

RELATIONSHIP TO YOU: ……. PHONE NO: …….

Please present the following to a receptionist to record your number
MEDICARE CARD / DVA CARD / PENSION CARD / HEALTHCARE CARD

PLEASE READ: Due to the new RACGP Accreditation Standards, patients must return for a follow-up appointment for all test results ordered by the GP. Full discussion and explanation of these results can then be documented and allow the opportunity for the patient to discuss the results with the Doctor. NO RESULTS WILL BE GIVEN OVER THE TELEPHONE

I agree that I will be responsible for full payment of any tax invoices incurred in my name because of a third-party claim consultation.

Signed: …… Date: ……

PRIVACY: This practice is committed to maintaining the confidentiality of your personal health information. Your medical record is a confidential document. It is the policy of this practice to always maintain security of personal health information and to ensure that this information is only available to authorised members of staff.

PLEASE COMPLETE CONFIDENTIAL PATIENT INFORMATION OF NEXT PAGE >>>>

Do you have any medical problems?
For example, high blood pressure, heart disease, high cholesterol, breathing conditions, cancer, mental health problems, skin disorders.

Have you had any surgical procedures?

Do you have any allergies to medications? _____

Do you smoke? NEVER / NO / Gave up when? _____ / YES / How many/day? _____

Do you drink alcohol? NO / YES, how many glasses per week? _____

Do you regularly exercise? NO / YES, how often per week? _____

Do you have pap smears? NO, why? _____
YES, when was your last one and was it normal? _____

Do you have mammograms? NO / YES, when was your last screening? _____

Please list any family medical history.
For example, heart disease, cancer, diabetes, blood clots, mental health.

Please list all medications taken regularly, including vitamins or any herbal supplements.

Please list any other Doctors / Specialists that you attend.

Have you been immunized for?

Influenza		Tetanus			
Pneumonia		Whooping Cough			
Hepatitis B		Other:			