SURNAME: ……………………………………………………………………………… TITLE: MR / MRS / MISS / MS / OTHER …………………..

CHRISTIAN NAMES (same as on your Medicare card)……………………………………………………………………………………………………

PREFERRED NAME: …………………………………………………………………… DATE OF BIRTH: …….……./…………………./…………………..

ADDRESS: ……………………………………………………………………………………………………………………………………………………………………..

SUBURB: ………………………………………………………………………………….. POSTCODE: ……………………………………………………………..

MOBILE NUMBER: …………………………………………………………………… WORK NUMBER: …………………………………………………….

HOME NUMBER: …………………………………………………………………….. EMAIL: ……………………………………………………………………

IF NEEDED, CAN WE CONTACT YOU BY: 🞏 eMail 🞏 SMS 🞏 Phone message 🞏 Mail 🞏 All of these

CULTURE: 🞏 ABORIGINAL 🞏 T.S.I. 🞏 BOTH 🞏 OTHER ………………………………………………………………………….

COUNTRY OF BIRTH: ……………………………………………………… PLACE OF BIRTH: ……………………………………………………………..

DO YOU REQUIRE THE SERVICES OF AN INTERPRETER: 🞏 YES 🞏 NO

WOULD YOU LIKE HELP TO REGISTER FOR AN ELECTRONIC HEALTH RECORD: 🞏 YES 🞏 NO 🞏 UNSURE

MEDICARE CARD NUMBER: ………………………………………………………… REF: ……………………. EXPIRY: …………………………………

PENSION NUMBER: …………………………………………………………………………………………………….. EXPIRY: …………………………………

HEALTHCARE CARD NUMBER: …………………………………………………………………………………….. EXPIRY: …………………………………

DVA CARD NUMBER: ………………………………………………………………………………………………….. COLOUR: ………………………………

IN CASE OF AN EMERGENCY CONTACT PERSON: ………………………………………………………………………………………………………….

CONTACT NUMBER: …………………………………………………………….. RELATIONSHIP TO YOU: ………………………………………….

NEXT OF KIN: ……………………………………………………………………………………………………………………………………………………………….

CONTACT NUMBER: …………………………………………………………….. RELATIONSHIP TO YOU: ………………………………………….

IF YOU HAVE A CARER WHAT IS THEIR NAME AND PHONE? ………………………………………………………………………………………..

IF YOU ARE A NEW PATIENT TO THIS PRACTICE, WHAT IS THE NAME AND ADDRESS OF YOUR PREVIOUS MEDICAL PRACTICE? …………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

ALLERGIES: 🞏 YES (write allergies below including reaction) 🞏 No known allergies

|  |  |
| --- | --- |
| Allergic To: | Reaction: |
|  |  |
|  |  |

ARE YOU TAKING ANY PRESCRIBED MEDICATIONS OR UNPRESCRIBED MEDICATIONS? 🞏 YES 🞏 NO

|  |  |
| --- | --- |
| Name of Medication: | Dose or strength if known: |
|  |  |
|  |  |
|  |  |

DO YOU HAVE ANY DIAGNOSED CONDITIONS?

* DIABETIES 🞏 HEART DISEASE 🞏 ASTHMA 🞏 COPD 🞏 HIGH CHOLESTEROL 🞏 HIGH BLOOD PRESSURE
* CANCER 🞏 OTHER …………………………………………………………………………………………………………………………………………

FAMILY HISTORY: (Disease or conditions present in immediate blood relatives) ……………………………………………………………………………………………………………………………………………………………………………………..

SOCIAL HISTORY: (Social, occupational, recreational aspects that may be significant to your medical history, e.g. diet, substance use, etc.) ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

SMOKING STATUS: 🞏 Current Smoker (doesn’t want to quit) 🞏 Current Smoker (wants to quit) 🞏 Ex-Smoker (less than 12 months ago) 🞏 Ex-Smoker (more than 12 months ago) 🞏 Never smoked

ALCOHOL CONSUMPTION: 🞏 More than 3 standard drinks per day 🞏 2 or less standard drinks per day 🞏 Occasionally 🞏 Non-Drinker 🞏 Ex-Drinker

HEIGHT: ……………………………………………….. WEIGHT: ……………………………………………………….

|  |
| --- |
| **INFORMATION COLLECTION CONSENT FORM** |
| As a patient of our medical clinic **we need your personal details and full medical history** so that we can properly assess, diagnose and treat you. We also need your input into your treatment so will work together for your long term better health.  **We will protect your privacy** and meet the National Privacy Principles. Only the clinical staff (doctors, nurses health workers) have access to your health records. Sometimes we have to share your information with other doctors or specialists that we refer you to.  **We need your consent to use your information**. De-identified data may be used to help with things such as funding applications, administration of the clinic, and quality assurance and compliance**. This information does not identify you, and you can ask for a copy of our privacy policy.**  🞏 I have read the information above and understand why my details are collected  🞏 I consent to Njernda Medical Clinic using my details for the reasons above.  🞏 If de-identified information is needed, you will be asked for consent first.  🞏 I understand I don’t have to disclose information if I don’t want to, but this may mean my treatment could be compromised  🞏 I am aware of my right to access my information |
| SIGNATURE: DATE: |