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| **Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex:** Male/ Female/ Other  **First name: ­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Surname:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date of Birth:** \_\_\_\_/ \_\_\_\_ / \_\_\_\_\_\_ **Country of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Medicare No:** \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ **Reference (** \_\_\_\_ **) Expiry Date:** \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_  **PLEASE CIRCLE:** Pension/Health Care Card **No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Expiry Date:** \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_  **DVA No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Type of Card** - **PLEASE CIRCLE:** GOLD / WHITE / ORANGE  **PLEASE CIRCLE:** Aboriginal/ Torres Strait Islander/ Both **Mobile**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Suburb:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Post Code:** \_\_\_\_\_\_\_\_\_\_\_  **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Do you consent to SMS recalls/reminders?** Yes / NO | | | | | |
| **EMERGENCY CONTACT/ NEXT OF KIN**  **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Contact Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to you:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **ALLERGIES:** (PLEASE CIRCLE) Nil Known / Yes - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **Do you smoke?** No/ Yes \_\_\_\_\_\_ / day | | | **Do you drink alcohol?** No/ Yes - how many\_\_\_\_/ week? | | |
| **Do you have a family history of? (PLEASE CIRCLE) (M = Mother F = Father)** | | | | | |
| CANCER: | M | F | STROKE: | M | F |
| DIABETES: | M | F | DEPRESSION: | M | F |
| HEART DISEASE: | M | F | HYPERTENSION: | M | F |
| **Patient Privacy Consent** I Certify that the above information is true and correct and authorise this practice to contact my nominated next of kin if warranted. I take responsibility for notification of any change to my contact details. I have read the information on the next page and understand the reasons why my information must be collected. I am aware that Marshall Lane Medical Centre has a privacy policy on handling patient information. I understand that I am not obliged to provide any information requested of me, but my failure to do so might compromise the quality of health care treatment. I am aware of my right to access the information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.  **Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ **Guardian/POA Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ | | | | | |