**TITLE:** MSTR /MR/ MRS / MISS / MS / OTHER:\_\_\_\_\_\_\_\_\_\_\_SURNAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST NAMES: (As shown on your Medicare Card)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREFERRED NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Numbers: H:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ W:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If needed, how may we can contact you: □ Email □ SMS □ Phone Message □ Mail □ All Listed

□ Boby John

Were you born in Australia? □ Yes □ No If not where were you born:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cultural Background: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*e.g. Greek/Indian/Italian)*

Do you require the services of an interpreter?: □ Yes □ No

Are you of Aboriginal and/or Torres Strait islander Origin? □ Yes □ No.

□ Aboriginal  □ Torres Strait Islander □ Both

Who do you live with at home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Medicare / Concession Card Details** |

Medicare Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ref No:\_\_\_\_(*Number next to your name*) Valid to:\_\_\_\_\_\_\_\_\_\_\_

Pension Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Valid to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Valid to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.V.A Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gold/White Card:\_\_\_\_\_\_\_\_\_\_\_Valid to: \_\_\_\_\_\_\_\_\_\_\_\_

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| **Emergency Contact Details** |

Next of kin/ In case of Emergency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact if different to the N.O.K:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have a carer, what is their Name and Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are a new patient to this practice, what is the name and address of your previous Medical Practice:

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| **Consent** |

**Patients Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: Missed appointments attract a fee of $35 for a single appointment and $70 for a double missed appointment. Cancellations without at least 12 hours notice may also attract a charge.

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| **Medical and Social History** |

**Allergies:** □ Yes (write allergies below including reaction) Allergies: □ No

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

**Are you taking any prescribed medications or Unprescribed Medications?** □ Yes □ No

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

**Do you have any Diagnosed conditions?**

□ Cancer □ Diabetes □ Heart Disease □ COPD □ Asthma □ High Cholesterol □ High blood pressure □ Stroke □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** (Disease or conditions present in immediate blood relatives)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:** (Social, occupation, recreational aspects that maybe significant to your medical history, eg.diet, substance use, etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| SMOKING STATUS: □ Never Smoked | ALCOHOL CONSUMPTION: □ Non Drinker |
| □ Current Smoker (Doesn’t want to quit) | □ Occasionally |
| □ Current Smoker (wants to quit) | □ Ex- Drinker |
| If so, how many per day?: | □ 2 or less standard drinks per day |
| □ Ex-Smoker (less than 12 months ago) | □ More than 3 standard drinks per day |
| □ Ex-Smoker (more than 12 months ago) | □ Weekly □ Monthly |
| What date did you give up smoking?: | Are you concerned about drinking? □ Yes □ No |

What is your current (if known): Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **INFORMATION COLLECTION CONSENT FORM** |
| As a patient of our medial 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 must 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 Healthworks Golden Square 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.  □ I consent for my scripts to be sent via E-script.  □ I consent to information being sent via encrypted email and Short Message Service(SMS). |
| Patients Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signed as Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name (printed) |