***Family name: ____________________*Given names:____________________ *DOB:_________**

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Preferred name: ______________________ **Title:** __________

Marital status: S M D W Sep **Gender** **Pronoun**

Aboriginal/Torres Strait Islander/ ethnicity: _______________________

***Address :** ____

____

City/Suburb: __________________ **Post code:** ____________________

Home phone: __________________

***Mobile:** __________________

Email: ____

***Consents to contact by email and/or SMS: Yes / No**

Smoke: Alcohol:

Allergies:

Regular Medications

Past medical history:

***Medicare number:**	**Medicare IRN:**	**Expiry date:**
Pension card type:	**Pension no:**	**Expiry Date:**
DVA number:	**Conditions:**	**Expiry date:**
Head of family:	**Relationship:**	**Mobile no:**
Next of kin:	**Relationship:**	**Mobile No:**
Emergency contact:	**Relationship:**	**Mobile No:**
Occupation:	Hearing/vision impaired?	

Vaccines	Dates		
Tetanus			
Polio			
Hep A			
Hep B			
Typhoid			

Family History

We collect your information so that we may properly assess, diagnose, treat and be proactive in your health care needs. Your information is confidential and will not be released without your permission but may be used in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral for medical tests and in the reports or results returned to us following the referrals
- Disclosure to other doctors, locums and Registrars in the practice for the purpose of patient care and teaching.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to ‘opt out’ of any involvement.
- Your signature will be used to verify any communication you may have with us.

You can access information collected except in some circumstances where access might legitimately be withheld. We will give an explanation if this happens. If you request access to information the practice is entitled to charge a fee to cover time spent by doctors to review files and administrative staff to prepare documents, including photocopying and other disbursements.

I consent to the handing of my information by the practice for the purpose set out above.

***Signature** ___________________________________ **Date** ______________________

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