BERRIGAN FAMILY MEDICAL CENTRE

PATIENT DETAILS

Title…….. First Name…….. Last Name…….

Preferred Name …….. D.O.B …….. Gender …….

Address …….

Suburb …….. Postcode…….. Occupation ……

Home …….. Mobile…….. Work ……..

Email Address: …….

Medicare No. …….. Ref No. …….. Exp ……

HCC/Pension Number …….. Exp……..

Vet Affairs ……..Gold /White /Orange Exp……..

What is your Ethnic Background/ Country of Birth ……

Do you identify as Aboriginal or Torres Strait Islander: **YES / NO**

If Yes, please indicate whether you are:

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

NEXT OF KIN DETAILS

Title…….. First Name…….. Last Name……

Address ……..

Phone…… Relationship ……

☐ If Emergency Contact Same as Next of Kin

EMERGENCY CONTACT (if different from Next of Kin)

Title…….. First Name…….. Last Name……

Address ……..

Phone……Relationship ……

PLEASE TURN OVER

MEDICAL HISTORY-

Allergies ……

……

Medical Conditions/Diseases……..

……

Current Medications ……

Are you a smoker? **Yes / No** If yes, how many per day? ……..

Are you a Previous Smoker? **Yes / No** If yes what year did you Quit? ……..

Do you Consume Alcohol? **Yes / No**

Number of days per week? …….. Number of Drinks per day? ……..

ACCIDENT AND INJURY DETAILS is your appointment for either:

Worker's Compensation? **YES / NO** Motor Vehicle Injury or Accident? **YES / NO**

Please be advised that until a claim number has been received you will be privately charged for all Worker's Compensation or Motor Vehicle visits and will be required to pay on the day of the visit and claim the visits back from your employer or the appropriate insurance department.

CONSENT

To enable ongoing care and total quality improvement within this practice, and in keeping with the Australian Privacy Principles (2014), we wish to provide you with sufficient information on how your personal health information may be used or disclosed. By signing below, you (as a patient/guardian) are consenting that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall notices for treatment and preventative health care including email and SMS.
- For accounting procedures and the collection of professional fees
- The diagnosis and treatment of my condition, including the communication of relevant information only, to practice staff, specialists and other health care providers to ensure quality care is provided.
- For legal related disclosures required by the court of law or for disease notification as required by law
- For use when seeking treatment by other doctors in this practice
- For obtaining medical records, previous clinical reports and management regimes, etc. from other medical practitioners, institutions, laboratories etc.
- To inform the next of kin identified in my patient information of the outcome of treatment or to obtain consent to necessary treatment when I am not able to provide such consent

Patient Name …… Signature ……

Guardian Name …… Date ……

<u>Guardian details only required for children under 16years of age</u>