Mr. Mrs. Miss Ms Master Dr Religious Title Other **PLEASE PRINT CLEARLY**

First Name: ______________________ **Middle Name:** ___________________ **Preferred Name:** __________________________

Surname: ______________________________________ **Date of Birth:** ___/___/____ **Sex:** Male / Female / Transgender

Medicare Card Number: ____________________________ **Reference Number:** _______ **Expiry Date:** ____/____

HCC / DVA / Pension Number: ________________________ **Type of Pension:** ________________ **Expiry Date:** ____/____/____

These Cards MUST be Presented to Reception

Address: ____ Suburb: _______________________ Post Code: ___________

PO Box: ____ Suburb: _______________________ Post Code: ___________

Home Phone: _______________________ Work: ______________________ Mobile: ____________________________

Email: ____

Preferred method of Contact: Home Phone / Work Phone / Mobile / Email / Post / Text Message

Marital Status: Single / Married / Widowed / Divorced / De-Facto / Separated

Cultural Background/Ethnicity (Chinese, German etc.):__________________________

Do you self-identify as being: Aboriginal: Yes/No Torres Strait Islander: Yes/No Not stated:_________

Occupation: _______________________ **Country of Birth:** _______________________ **Year Arrived in Australia:** ___________

Preferred Language Spoken: _____________________ **Health Insurance:** None / Basic Hospital / Intermediate / Top Hospital

How did you find us: [ ] Website [ ] Yellow/White Pages Online [ ] Yellow/White Pages Directory [ ] Google [ ] True Local

[ ] Facebook [ ] Referred [ ] Newspaper [ ] Other ________________________

Next Of Kin: _________________________________ Ph: ______________________ Relationship to you: ____________________

Emergency Contact: ___________________________ Ph: ______________________ Relationship to you: ____________________

Patient Consent Form

From 21 December 2001 the Privacy Act requires private medical practices to obtain your consent to collect personal information about you. Please read this information carefully and sign where indicated below. The medical practice collects information from you for the primary purpose of providing necessary health care. We require you to provide us with your personal details and full medical details so that we may assess, diagnose, treat and be proactive in your health care needs properly and we will use the information you provide us in the following ways: Recall & reminder system, if you do not wish to be included please let the staff know.

Consent to receive text messages from the clinic: [ ] YES [ ] NO

Administrative purposes in running our medical practice; billing purposes, including compliance with Medicare & health Insurance Commission requirements; Disclosure to other doctors in the practice including locums for your ongoing care if your usual doctor is not available; Disclosure to others involved in your health care, including treating doctor and specialists outside this medical centre. This may occur through referral to other doctors or medical tests and in the response or results returned to us following referrals. **I assign my right to benefits to the practitioner who rendered this service.**

Disclosure for statistical research and quality assurance activities to improve individual and community health care and practice management. Please be advised that your personal details such as your name address and date of birth are withheld in these situations. Therefore your identity is protected. You may elect for your information to be excluded in such activities. Please place a line through this clause if you prefer your information to be excluded.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient's information. I understand that I am not obliged to provide any information requested of me but that failure to do so might compromise the quality of health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might be withheld. I understand I will be given an explanation in these circumstances. I have been advised of the estimated costs in respect of the proposed medical services**. I accept responsibility for payment of this account, including if any nominated insurer does not pay the anticipated costs or declines liability of any injury claims.**

SIGNED (patient, parent or guardian): ____ DATE**:** ________________

COORPAROO CLINIC

NAME: ____ **Date of Birth:** / /

Gender: Male / Female / Transgender

Cultural background / Ethnicity (Chinese, German etc):___________________________________

Do you self-identify as being: Aboriginal: Yes/No **Torres Strait Islander:** Yes/No

Do you live alone? Yes/No Do you have local family support? ____________________________

Do you have any children? Yes/No ________ How many still living at home? ____________

Have you ever served in the Australian Defence Forces? ____________________________________

Health Insurance: None / Basic / Intermediate / Top **Fund:** __________________

HEIGHT: ______________________________ **WEIGHT:** ___________________________________

ALLERGIES: Do you have any known allergies to medications, food or insect bites? □ Yes / □ No

If Yes - Allergic to: ____

MEDICAL HISTORY:

Have you or a family member ever suffered from any of the following – currently or in the past?
Please tick or write relative's title e.g. Mother/Father/Sibling/Grandparent

Disease	You	Family Member	Disease	You	Family Member
Heart Condition			Stroke		
High Blood Pressure			Fractures		
High Cholesterol			Bowel Cancer/Polyps		
Asthma			Breast Cancer		
Diabetes			Cervical/Ovarian Cancer		
Epilepsy			Prostate Cancer		
Thyroid Disease			Any other Cancer		
Osteoporosis			Other		
Arthritis					
Depression/Anxiety					
Mental Health					

If you answered yes to any of the above please give details and which year diagnosed:
____
____

OPERATIONS: Have you had any operations? Please name them and the year performed.
____
____

CURRENT MEDICATIONS: please list, including over the counter medications, vitamins etc
____
____
____

COORPAROO CLINIC

SMOKING:
Have you ever smoked? □ Yes/ □ No
Ex-Smoker - What year did you quit? ________
Smoker - how many per day? ______________ What year did you commence? ______________
Are you planning to quit? □ Yes/ □ No

ALCOHOL:
How often do you drink alcohol?
□ Never, □ Monthly or Less, □ 1-2 days per Month, □ 1-2 days per Week , □ 3-4 days per week,
□ Daily
On a day that you drink how many standard drinks do you have? __________________
Would you ever have more than 6 standard drinks on 1 occasion? □ Yes/ □ No
(If yes) How often? □ Daily □ Weekly □ Monthly □ Less than Monthly

Are you concerned about your drinking: Yes / No / Don't Know

IMMUNISATIONS:
Please list what immunisations you have had and when you had them

Immunisation	Date	Immunisation	Date
Tetanus		Pertussis (Whooping Cough)	
Hepatitis A		Polio	
Hepatitis B		Yellow Fever	
Influenza (Flu)		Typhoid	
Pneumococcal (Pneumonia)		Other	

If completing this form for a child, are their immunisations up to date?
□ Yes / □ No

Have you ever travelled overseas in the last 12 months □ Yes/ □ No
If so where and when
____

FEMALE PATIENTS:
What month & year was your last Pap Smear? ________/__________ was it Normal □ Yes/ □ No
Have you ever had a Mammogram or Breast Check? □ Yes/ □ No When ______/_______

MALE PATIENTS:
Have you had a prostate check-up? □ Yes / □ No When___________/________
Have you ever had a screening for **Bowel Cancer**? _____________________ Result: _______________

Preferred Method of Contact: Email / Letter / Phone / SMS

I consent to receive recalls and health reminders for immunisations, pap smears, health checks etc [ ] YES [ ] NO

Signed: ____ **Date: / /**

PLEASE PRINT NAME: ____

Thank you for taking the time to complete this questionnaire.