We are committed to providing our patients with the best care. To do this it is essential that your contact details are kept up to date and accurate.

Title	**Mr** **Mrs** **Ms** **Miss**		
Surname			
First Name		**Date of Birth**	
Birth Sex: Male / Female / Other / Unknown	**Gender Identity**: Female / Male / Non-Binary / Transgender / Different		
Do you identify with any specific cultural background? Aboriginal ☐TSI ☐No	**Ethnicity:** ……		
Street Address			
Suburb and Post Code			
Phone Numbers:	**Landline:**	**Mobile**:	
	Do you consent for us to sending SMS reminders to this mobile for appointments, clinical test results and clinical reminders eg skin check/cervical screen ? Yes / No		
Email :			
Medicare Number & Ref		**Expiry**	
DVA Gold or White		**If white card – what conditions:**	
Pension Number		**Expiry**	
Health Care Card		**Expiry**	
Private Health Cover			
Next of Kin	(Name and Telephone number)	(Relationship)	
Emergency Contact (Different person)	(Name and Telephone number if NOK unavailable)	(Relationship)	

THE PRIVACY ACT (2001) – Consent for Use of Information:

We are committed to protecting your privacy. Please read the attached 'Privacy Policy'. We are now asking for your express consent for the use and disclosure of your personal health information in the course of your health care. I confirm that the information I have given (on this form) is correct. I consent to sharing of all relevant information between the general practitioners, specialists, nurse practitioners, nurses, allied health providers and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfil their duties in the course of planning and managing my health care.

Full Name: …… Signed: ……

On behalf of: …… Date: ……

HOW did you hear about our Practice? ……

WHY did you choose our Practice? ……

Do you have any allergies or are you sensitive to drugs or dressings:

☐ Yes (please list below WITH REACTION THAT WAS EXPERIENCED) ☐No

……

Family history - have any members of your family had:

☐ Diabetes ☐ Asthma ☐ Heart Disease ☐ Mental illness ☐ Cancer ☐ Other …….

Social history:

☐ Tobacco: ……. day / week or Ceased Smoking - date ……

☐ Alcohol: ……..day / week …….. days/week

☐ Drug use: …… (type and frequency)

Females: When did you last have?

Pap smear/CST Date …….. ☐ not sure ☐ never

Breast Check Date ……. ☐ not sure ☐ never

Males: When did you last have?

An overall check up Date …….. ☐ not sure ☐ never

Children's immunisations - if completing this form for a child are their immunisations up to date?

☐ Yes ☐No

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander ☐ No

Reminder Systems:

Our practice provides our patients with preventive care and early case detection reminders e.g. immunisations, annual health checks, skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you?

☐ Yes – mail ☐ Yes – SMS to this phone number ……☐ No

If we need to contact you what is your preferred method of contact:

☐ Home phone ☐ Mobile phone ☐ Mail ☐ Email