Patient Details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Master ☐ Other ☐ : _____

Given Name/s: _____
Surname: _____

Birth Sex**:** Male / Female
Gender Identity**:** Male / Female / Non-binary / Transgender / Other: _____
Preferred pronouns: He-Him-His / She-Her-Hers / They-Them-Theirs

Are you of Aboriginal descent Yes ☐ No ☐ Torres Strait Islander descent Yes ☐ No ☐

Date of Birth: ____ / _____ / _____
Home Address: _____
_____
_____ Post Code: _____

Contact Numbers
Home _____
Work _____
Mobile _____
Email address: _____@_____

Medicare Number: ☐☐☐☐ ☐☐☐☐☐ ☐
Reference Number: ☐ **(the number left of your name)**
Expiry Date: / **(found at the bottom right of the card)**

Dept. Veterans Affairs Number: ☐☐☐ - ☐☐☐☐☐
Gold ☐ or White ☐ - Conditions _____

Occupation: _____
Marital Status: _____
Country of Birth: _____
Next of Kin Name: _____
Relation to you (i.e. Wife): _____
Next of Kin Phone Number: _____
Your HCC or Pension Number: _____
Expiry Date: _____
Type of Pension (eg: Disability): _____

Do you have private health cover?

NO ☐ / YES ☐

HOSPITAL ☐

EXTRAS ☐

Which Health fund are you with?

_____

Member Number?

_____

CONFIDENTIALITY FORM:

- I agree to Boondall Family Practice **collecting my personal information** so that they can provide accurate, quality health services; including but not limited to sending clinical reminders, communications & health awareness messages via SMS.
- I agree that **information may be supplied to health care providers** in the diagnosis, management and / or treatment of my medical condition and these may include pathologists, radiologists and other specialists.
- I understand that my information will be kept confidential between my doctor and any other specialists that are involved in my health care, and **will not be released to a third party without my authorization**.
- I am aware of the privacy information poster on display in the waiting room, and I am also aware that there are privacy brochures available from reception staff and the doctor, regarding how my personal information is handled, and I am able to access or request copies at any time.

Signature_____ date___/___/_____

BRIEF MEDICAL SUMMARY **Date / /**

Name: _____

Date of Birth: ____ / ____ / _____

Do you smoke?	YES ☐	NO ☐
Do you drink alcohol?	YES ☐	NO ☐

ALLERGIES
Please list, or tick - None ☐

_____

_____

_____

_____

Please note any significant **family** history

_____

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS
Medications you are currently taking, or tick - None ☐

_____ (Dose:)

_____ (Dose:)

_____ (Dose:)

_____ (Dose:)

_____ (Dose:)

_____ (Dose:)

_____ (Dose:)

SIGNIFICANT PAST MEDICAL HISTORY
Have you ever had any significant illnesses or any operations? Please list, or tick – None ☐

_____ (Year:)

_____ (Year:)

_____ (Year:)

_____ (Year:)

_____ (Year:)

Thank-you for taking the time to fill out this form ☺