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 E-scripts, clinical reminders, communications & health awareness messages via SMS and/or email.
- 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 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____/____/______

PLEASE TURN OVER FOR PAGE 2

BRIEF MEDICAL SUMMARY

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 ☺

If you have downloaded & completed this form prior to your appointment you are welcome to email us on:
reception.boondallfamily@gmail.com