Patient Details

We are not a bulk billing practice: by filling this form you agree to pay the fees. (Handouts available at reception)

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

Given Name/s: _____

Surname: _____

Date of Birth: ____ / _____ / _____

Birth Sex: Male / Female

Gender Identity: Male / Female / Non-binary / Transgender / Other: _____

Preferred pronouns: He-Him-His / She-Her-Hers / They-Them-Theirs

Marital Status: Single ☐ De Facto ☐ Married ☐ Divorced ☐ Other: _____

Country of Birth: Australia ☐ Other: _____

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

Occupation: _____

Exposure to: Asbestos ☐ Animals ☐ Radiation ☐ Silicosis ☐

Contact

Home Address: _____

_____ Post Code: _____

Postal (if different): _____

Mobile: _____ Home Ph: _____

Email address: _____

Medicare

Card Number: ☐☐☐☐ ☐☐☐☐☐ ☐

Reference Number: ☐

Expiry Date: ____ / _____

DVA

Card Number: ☐☐☐-☐☐☐☐☐

Gold ☐ or White ☐

Next of Kin

Name: _____ Contact: _____

Relation to you: (e.g. Wife): _____

Concession

Health Care Card ☐ Pension card ☐ Commonwealth Seniors card ☐

Card Number: _____ Expiry date: ____ / _____ / _____

Confidentiality and Consent

- I agree to Boondall Family Practice **using my personal information** to provide accurate, quality health services; including but not limited to sending E-scripts, clinical reminders, communications and health awareness content 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 authorisation**.
- I am aware that there are fees and privacy leaflets available from reception staff, regarding how my personal information is handled, and I am able to access or request copies at any time.
- By singing this form you consent to the doctor, should they deem it appropriate, bulk billing part or all of your consultation without the need to obtain your signature on every occasion. We are not a bulk billing practice: by filling this form you agree to pay the fees.

PLEASE TURN OVER FOR PAGE 2

BRIEF MEDICAL SUMMARY

Name: _____

Date of Birth: ____ / ____ / _____

What is your smoking/vaping status?

Current smoker … ☐ Current vaper … ☐

Ex-smoker …….. ☐ Ex-vaper…… ☐

Never smoked or vaped …. ☐

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: _____)

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 ☺

Signature_____ **Date**___/___/_____

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