

KEY INFORMATION

Full Name Mr Mrs Ms Miss Dr

Date of Birth / /

Postal Address

Postcode

Phone

Mobile

Wk

Email address

Emergency Contact Person

Relationship to you

Contact phone No (mobile)

Home

BILLING ELIGIBILITY

Do you have private health cover? Yes No

Name of Insurer

Are you (please circle if filling in by hand or click on button if filling in electronically)

Aboriginal Torres Strait Islander Non Indigenous

Medicare No. or Vet Affairs

Ref no Next to name Expiry

Do you have a DVA Gold or White Card (please circle)

DVA Gold Card DVA White Card

If yes, please specify details:

DVA Gold Card # DVA White Card #

Pension / Health Care Card no

Expiry

PREFERRED COMMUNICATION

Preferred method of communication?

Phone

Mail

Email

Would you like to receive our newsletter electronically?

Yes

No

Office Use Only – Staff Please tick the correct item number for Health Insurance Commission

- Chronic Condition - Item 721 GPMP
- Medication review - Item 900
- Over 65 Flu / Pneumo

- Chronic Condition - Item 723 TCA
- Diabetes - Item 2517
- Mental Health Plan - Item 2710

- 45-49 - Item 721
- Over 75 - Item 700, (Home 702)
- Other _____

FEEDBACK

How did you find out about our surgery? (please circle if filling in by hand or click on button if filling in electronically)

- Word of Mouth
- Signage outside practice
- Pharmacy
- Radio 91.9 What's up Doc?
- Beyond Blue
- Sunshine Coast Tourism magazine
- White Pages
- Drive / Walked past
- School newsletter
- Kids on the Coast
- Search engine – google
- Search engine – other
- Other (please specify)
- Holiday Accom
- Yellow Pages
- Bowls club
- Beach House Fitness
- Relatives
- Leaflets / flyer
- The Weekender
- SALT magazine
- Link from a website

OFFICE PURPOSES ONLY	
Action	Date
Appointment received	
Entered database	
Appointment confirmed	

KEY MEDICAL INFORMATION

PATIENT NAME:

PATIENT D.O.B

OCCUPATION:

Please list current medications including vitamins and herbal medicine intake

Please list any allergies

Please list any medical history and past surgery/operations /previous illnesses/injuries

IMMUNISATIONS (please tick relevant boxes)

- Pneumococcal (pneumonia) Influenza Tetanus
 Childhood vaccines up to date Other (please specify)

GENDER RELATED HEALTH HISTORY

Women's Health (specify approx month/year)

Last pap smear
Last mammogram (if aged over 50)

Men's Health

Last prostate check (if aged over 40)

LIFESTYLE HEALTH HISTORY

Smoking history (please tick box)

- Never
 Former smoker – quit date
 Current smoker - /day
Number of years smoking

ALCOHOL

- Non-drinker
 Rarely/light
 Moderate
 Heavy

Please list any other recreational drug use. Please note your answers will remain confidential:

FAMILY HISTORY

Have you ever had or family history of (please circle if filling in by hand or click on button if filling in electronically)

- Diabetes Mum Dad Sibling Grandparent Other
Heart disease Mum Dad Sibling Grandparent Other
Stroke Mum Dad Sibling Grandparent Other
Asthma Mum Dad Sibling Grandparent Other
Cancer Mum Dad Sibling Grandparent Other

If yes to cancer question, please specify what kind:

CONSENT

I consent to the use of my personal health information by the Medicine on Second and other health providers involved in my medical treatment and health care.

I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment

Signature

Date / /

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