WOODVALE PARK MEDICAL CENTRE

PATIENT INFORMATION & CONSENT FORM

PATIENT DETAILS

Surname | **Given Name/s**

Preferred Name | **Title:** ◯ *Mr* ◯ *Mrs* ◯ *Miss* ◯ *Ms* *Other*

Marital Status: ◯ *Married* ◯ *Divorced* ◯ *Widowed* ◯ *Single* **Gender** ◯ *Male* ◯ *Female* ◯ *Other*

Address | **Postcode**

Telephone: *Home* | *Mobile* | **Date of Birth**

SMS Reminders: *Are you happy to receive SMS reminders (via HealthEngine) for appointments and recalls?* ◯ *Yes* ◯ *No*

Ethnicity* | **ATSI Status*** ◯ *Aboriginal* ◯ *Torres Straight Islander*

Religion | **Occupation:**

Medicare Card: *N°* | *Ref* | *Expiry*

Veterans Affairs: *N°* ◯ *Gold* ◯ *White* *Expiry*

Commonwealth Seniors Card: *N°* *Expiry*

Pension Card: *N°* *Expiry*

Health Care Card No: *Expiry*

Head of Family/Account Holder: *Name* | *Date of Birth*
(if different from above)
Address | *Postcode*
Medicare No | *Ref* | *Expiry*

Next of Kin: *Name* | *Relationship to Patient*
Phone | *Mobile*

Emergency Contact: *Name* | *Phone*

1. ACCIDENT & INSURANCE DETAILS

Is this visit related to:

Workers Compensation? ◯ *Yes* ◯ *No* **Employer Name**
Employer Phone: **Contact Name**

Motor Vehicle Accident? ◯ *Yes* ◯ *No*
Date of Accident: **Claim No:**

2. CONSENT

I understand that Woodvale Park Medical Centre needs to collect information for the primary purpose of providing quality health care to properly assess, diagnose and treat my health care needs. The above information can be used by Woodvale Park Medical Centre in the following ways:

- ☐ Collect, use and store personal details;
- ☐ Release of relevant personal information to other health professionals to allow quality medical care (eg specialist, pathologist);
- ☐ Inclusion in a recall reminder register to be advised of follow-up visits and health information;
- ☐ Release of relevant personal information to my (prospective) employer, their authorized representative and their insurer in the case of a work related consultation or service; or
- ☐ Uploading of health summaries for immunisation, new medications etc to your personal eHealth record.

Signature | Date

** Please complete these fields even if known*

IMPORTANT INFORMATION

Please ensure that you provide true and thorough information for doctors.

Are you Allergic?

Allergic to: *(drug name, food, other)*	Nature of Reaction

Other Info

Family Health History

MOTHER:

Alive ◯ *Yes* ◯ *No* Age at Death Cause of Death

☐ *Diabetes* ☐ *Hypertension* ☐ *Heart Disease* ☐ *Stroke* ☐ *Breast Cancer* ☐ *Colon Cancer* ☐ *Depression*

(check all that apply)

FATHER:

Alive ◯ *Yes* ◯ *No* Age at Death Cause of Death

☐ *Diabetes* ☐ *Hypertension* ☐ *Heart Disease* ☐ *Stroke* ☐ *Prostate Cancer* ☐ *Colon Cancer* ☐ *Depression*

(check all that apply)

Alcohol Intake

◯ None ◯ Rare ◯ Occasional ◯ Daily Standard drinks per day Drinking days per week

Other information

Smoking History

Have you ever smoked? ◯ Yes ◯ No Amount per day

Year Started Year Stopped Other info

Signature Date

Send Form Print Form Clear Form

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