# Patient Information Form

Welcome to The Clinic Williamstown. We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. Please complete the relevant information for the person seeing the doctor.

| | |
|---|---|
| **Title** | ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss |
| **Surname** | |
| **First Name** | **Preferred Name** |
| **Date of Birth** | |
| **Street Address** | |
| **Suburb and Postcode** | |
| **Home Phone** | |
| **Work Phone** | |
| **Mobile Phone** | |
| **Email** | |
| **If we need to contact you what is you preferred method of contact?:** | |
| **Occupation** | |
| **Marital Status** | |
| **If filling this form in for a child please provide details of payer so that Medicare can be claimed.**<br>**Name**<br>**Medicare Number & Ref #** **DOB:**<br>**Address:** | |

| | | |
|---|---|---|
| Medicare Number & Ref | # | Expiry |
| ☐ DVA Gold ☐ DVA White | # | Expiry |
| Pension Number | # | Expiry |
| Health Care Card Number | # | Expiry |
| Private Health Cover | Name | # |

| |
|---|
| Next of Kin<br>Relationship<br>Telephone number |
| Emergency Contact: (Name and Telephone number of the person we can contact if needed. |

**Dependant children:**

| **Name** | **DOB** |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Patients Name :_____**

Country of Birth: _____

**To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?**
☐ No
☐ Yes – Aboriginal
☐ Yes Torres Strait Islander
☐ Yes Aboriginal & Torres Strait Islander

**Reminder Systems:**
This practice routinely sends SMS appointment reminders to patients
Consent for SMS Reminders ☐ Yes ☐ No

*The practice adopts a proactive approach to assist in the management of your health and wellbeing. We will communicate with you around various health related topics including preventative care, follow up health information and early case detection reminders and recalls. (We will not send junk mail)*

**Do you wish to have relevant health reminders sent to you?**
☐ Yes by SMS ☐ Yes by mail
☐ Yes by e-mail ☐ No
☐ Yes by phone

*The practice may participate in research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt-out".*

Consent for Participation in sharing of de-identified information ☐ Yes ☐ No
Would you like to receive our monthly electronic newsletter? ☐Yes ☐No

I _____ consent to this practice transferring my health information to other Health Providers for the purpose of my ongoing medical management.

Signed _____ Date_____

How did you find out about us?
☐Google ☐ Yellow Pages on line ☐ Yellow Pages Book
☐ True Local ☐ Word of Mouth ☐ Walk In
☐ Family ☐ Other _____

**Office Use Only**
Date of Registration
Photo ID Checked ☐

**Patients Name:**_____

**Patient Background:**
Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds.
**Do you identify as someone from a culturally and/or linguistic diverse background?**
☐ No
☐Yes Please elaborate (for example your country of birth or country of birth of parents)
_____

**Do you have or have you had a history of the following?** (Please elaborate)
☐ Operations
☐ Asthma
☐ Diabetes
☐ Hypertension
☐ Chronic Illness
☐ Cancer
☐ Other

**Have any members of your immediate family had: (**please elaborate**)**
☐ Heart Disease
☐ Asthma
☐ Diabetes
☐ Mental Illness
☐ Cancer Type -
☐ Raised Cholesterol
☐ High Blood Pressure

**Do you have any allergies or are you sensitive to drugs or dressings?**
☐ No
☐ Yes Please elaborate _____

**Do you use any of the following: (**list amount where appropriate)
Tobacco - ☐ No ☐ Yes Number _____day/_____week or
☐ Ex Smoker Year ceased smoking _____
Alcohol - ☐ No ☐ Yes Number_____ day/_____week/_____Month
Drug Use - ☐ No ☐ Yes Type _____/Frequency _____

**Please enter your: Weight _____ Height _____**

**Children's Immunisations:**
If completing this form for a child, are their immunisations up to date? ☐ Yes ☐ No

**Current Medications:**
Please list all current medications including over the counter medications, vitamins and minerals
_____
_____

**For those 65 years and older, when was the last time you were immunised?**
☐ Influenza _____
☐ Pneumococcal Pneumonia _____

**Females, when did you last have:**
Pap Smear _____
Breast check _____