HealthSense
MEDICAL CENTRE

Patient Detail Form (please complete both sides)

☐Mr ☐Master ☐ Mrs ☐ Ms ☐ Miss ☐ Other

Surname: Given Name: Middle Name:

Date of Birth: Age: Nationality: ____________________

☐ Australian ☐Aboriginal ☐Torres Strait Islander ☐Other ____________________

Street Address: City/Suburb: Postcode:

Home Phone: Mobile: Work Phone: E-mail:

Medicare Number: Ref No: (Next to Name) Expiry Date: (Bottom Right Corner)

How would you like your reminders sent: ☐ Phone / Mobile ☐ Post ☐ SMS

☐ Health Care Card No:______________ Expiry Date: _________ ☐ Pension Card No:______________ Expiry Date:________

☐ Department of Veteran Affairs Card Number: ______________________________ Expiry Date: __________________

Health Insurance Fund: ________________ Membership No: ____________________ Expiry Date: __________________

EMERGENCY CONTACT: I authorise the following person to be contacted in the case of an emergency:

Name: _______________________ Relationship: ____________________ Contact No: __________________

Family: ☐ Unknown (eg Adopted) ☐ No Significant Family History

Mother Alive ☐ Yes ☐ No Age of Death: ___________ Cause of Death ________________________

Father Alive ☐ Yes ☐ No Age of Death: ___________ Cause of Death ________________________

Significant Family History:

Mother: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ Breast Cancer

Father: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression

Marital Status ☐ Single ☐ Married ☐ De Facto
Elite Athlete ☐ Yes ☐ No
Breast Feeding ☐ Yes ☐ No
☐ Heterosexual ☐ Homosexual ☐ Bisexual

Do you have any allergies: ☐ Yes (Please List) ☐ No

____

Do you use any of the following: Past Alcohol Intake: ☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Alcohol ☐ No. ☐ Yes Days per week ______ Standard drinks per day ______ Year Started: _____ Year Stopped: _____

Smoker ☐ No. ☐ Yes How many per day _______ Year Started ___________ ☐ Ex-Smoker Ceased: _____

Accommodation: ☐ Own Home ☐ Relatives Home ☐ Private Lease ☐ Hostel ☐ Nursing Home
Lives With: ☐ Spouse ☐ Relative ☐ Friend ☐ Alone

Recreational Activities ________________________________ Occupation: ________________________

How did you get to know about us? ☐ Google ☐ Website ☐ Facebook ☐ Health Engine

☐ Letterbox/Leaflet ☐ Walk In ☐ Word of Mouth ☐ Chemist

☐ Other...

Please Complete Reverse

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Patient Privacy Information

Your personal health information will only be used for the management of your health care or as otherwise permitted by law. At all times we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

Signature: ___________________________________ Date: _________________________