HealthSense
MEDICAL CENTRE

Patient Detail Form (please complete both sides)

☐Mr ☐Master ☐ Mrs ☐ Ms ☐ Miss ☐ Other

Surname: Given Name: Middle Name:

Date of Birth:_____/_____/_____: Ethnicity: (other than Australian)_____

☐ Australian ☐Aboriginal ☐Torres Strait Islander **Occupation:**……..

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: _____

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

Name: _____ Relationship: _____ Contact No: _____

NEXT OF KIN:

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

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: _____

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

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

☐ Other……

PLEASE SIGN ON REVERSE SIDE

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Privacy Statement

Your Personal Health Information and your Medical Records may be collected, used and disclosed, including but not limited to the following reasons:

- **For Communicating relevant information with other treating doctors, specialists or allied health professionals**
- **For follow up reminders/recall notices**
- **For disease notification as required by law (e.g. infectious diseases)**
- **For use by all doctors in this practice, when consulting with you**
- **For research purposes (de-identified, meaning you are not able to be identified from the information given)**
- **For obtaining previous pathology and radiology results.**
- **For Uploading Information onto your personal 'My health Record'.**

If you have any concerns or wish to restrict access to your personal health information, please discuss these with your doctor.

Signature: _____ Date: _____