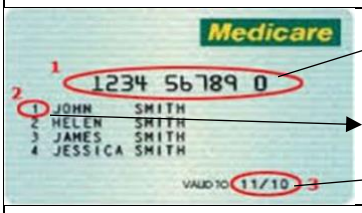
Brunswick Heads Medical Centre: Patient Information Sheet

Title: Dr/ Mr/ Mrs/ Ms/ Miss **Gender M F Other**

FIRST NAME **SURNAME:** **DATE OF BIRTH**



Medicare No

Reference NO

Expiry date

Concession card: (If applicable)

Expiry date:

Your Address (Held by Medicare)

POSTAL(if different)

Country of Birth : **Are you Aboriginal/Torres Strait Islander** **YES** **NO**

Cultural background (Ethnicity) **Occupation :**

Mobile Phone: **Home Phone:**

DVA No (if applicable)

Next of Kin **Relationship to you** **Phone No**

***Emergency Contact (if different*)** **Relationship to you** **Phone No**

Do you have any Allergies? **YES NO** *If yes, please list them:*

Do you drink Alcohol? **YES NO** *If yes, how many glasses per week on average?*

Do you Smoke Cigarettes? **YES NO** *If yes, how many cigarettes per day on average?*
Are you an EX-Smoker **YES NO**

Please list any Family Medical History (e.g. Heart disease, Cancer, Diabetes, Asthma ,High blood pressure, Mental health problems)

What is your preferred method for us to contact you when needed: **Via SMS or CALL ONLY**

If your phone is not answered, are we permitted to leave a voice mail or send an SMS? **YES** **NO**

Our Practice can provide you with Preventative Care Clinical Reminders,
(Such as health assessments, cervical tests, asthma, diabetes, immunisations skin checks etc.**)**
Do you consent to have these Clinical Reminders sent to you? **YES** **NO**
Please send these Clinical reminders by SMS only OR POST only

If SMS is not available- Email Address for **Preventative Care Reminders ONLY :**

I consent to sharing my health information with other Health professionals involved in my care: **YES** **NO**

If you are completing this form on behalf of a minor please add the following information:
Parent/guardian name **DOB** **Medicare card No**

* As per BHMC policy, I understand if I **fail to attend a booked /confirmed app without sufficient cancellation notification**, I am aware there is a *late cancellation / no show fee* that will need to be paid by me before or at my next consultation.

I confirm that I have read everything and all details completed on the form by me are correct:

Signature: **Date:**