

TO MAINTAIN YOUR MEDICAL RECORDS, IT IS NECESSARY TO HAVE THE FOLLOWING INFORMATION WHICH WILL BE HANDLED CONFIDENTIALLY.

MR / MRS / MS / MISS / MASTER / DR

GIVEN NAME: _____ SURNAME: _____

DATE OF BIRTH: _____

STREET ADDRESS: _____

SUBURB: _____

STATE: _____ POSTCODE: _____

PHONE: (H) _____

(W) _____

(Mobile) _____

EMAIL: _____

MEDICARE NO: _____ EXPIRY DATE: _____ REF NO: _____

ARE YOU IN A HEALTH FUND: YES / NO

IF YES, NAME: _____

MEMBERSHIP NO: _____ LEVEL OF COVER: _____

MEDICAL HISTORY:

DO YOU SUFFER FROM ALLERGIES TO: _____

ARE YOU: HIV+ YES / NO

ANTIBIOTICS: _____

HEP B+ YES / NO

STICKING PLASTER: YES / NO

HEP C+ YES / NO

MEDICATIONS: _____

OTHER: _____

EMERGENCY CONTACT DETAILS:

NEXT OF KIN: (NAME) _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE: (DAY) _____ (NIGHT) _____

WHO REFERRED YOU TO THIS PRACTICE:

DOCTOR / PATIENT / FRIEND / YELLOW PAGES / WEBSITE / OTHER: _____

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE THIS INFORMATION IS TRUE AND CORRECT.

SIGNATURE: _____ DATE: _____