

PERSONAL DETAILS

Title: _____ First Name: _____

Surname: _____ D.O.B. ____ / ____ / ____

Gender: _____ Country of Birth: _____

Are you of Aboriginal or Torres Strait Islander descent?

Yes No

Address: _____

Suburb: _____ Postcode: _____

Tel: H: _____ W: _____

Mobile: _____

Consent to SMS Yes No

Email: _____

Occupation: _____

MEDICARE DETAILS

Medicare Number: _____

Reference Number _____ Expiry Date: ____ / ____ / ____

Pension/Health Care Card Number: _____

Expiry Date: ____ / ____ / ____

DVA, which: ORANGE WHITE GOLD

DVA Number _____ Exp _____

EMERGENCY CONTACT

Name: _____

Relationship: _____ Tel: _____

Next of Kin (if different from above) _____

Relationship: _____ Tel: _____

How did you hear about us?

Word of Mouth Flyer/Mailbox Newspaper

Internet Passing By Werribee Hospital

Other (please specify) _____

ALLERGIES

Are you allergic or sensitive to any medications? YES NO

Health assessment/care plans _____

You may be eligible for a care plan or health assessment, please speak to our friendly staff.

FAMILY HISTORY

Has any member of your family been diagnosed with diabetes, a heart condition or any form of cancer? If yes please detail:

PAST MEDICAL HISTORY

Have you ever been a patient in a hospital, if so for what reason and in which year?

Are you a diabetic? YES NO If yes, Type 1 OR Type 2

When was your last Pap smear (Women Only)? _____

Do you suffer from high blood pressure? YES NO

Have you ever suffered from chest pain or shortness of breath?
YES NO

SOCIAL HISTORY

Do you smoke? YES NO

If YES, how many per day: _____

Have you previously smoked? YES NO

If YES, when did you give up smoking? _____

Do you drink alcohol? YES NO

If YES, how many days per week: _____

PRIVACY AGREEMENT AND PATIENT CONSENT

Privacy Agreement & Patient Consent: I understand that Hoppers Lane General Practice and associated Medical Centres comply with the Privacy Act (1988) and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Hoppers Lane General Practice collecting, using, storing and disposing of my personal information; the release of relevant personal information to relevant health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits; inclusion in national /state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorised representative and their insurer in the case of a work related consultation or service. I understand I may withdrawal my consent for Hoppers Lane General Practice to use and disclose my personal information (except where legal obligations must be met). I consent to transfer and use of de-identifier information.

SIGNATURE: _____

DATE: _____