HILLSCENE FAMILY MEDICAL CENTRE

NEW PATIENT INFORMATION FORM

TITLE: MR / MRS / DR / MS / MISS / MASTER (Please indicate)

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____ **POSTCODE** _____

PHONE: Mobile _____ Home _____ Work _____

EMAIL: _____

OCCUPATION: _____

MARITAL STATUS: SINGLE / DEFACTO / MARRIED / SEPARATED / WIDOWED / DIVORCED

COUNTRY OF BIRTH: _____ **ETHNICITY**: _____

PREFERRED LANGUAGE: _____ DO YOU NEED AN INTERPRETER? YES / NO

ARE YOU ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN? YES / NO _____

ABORIGINAL ☐ **TORRES STRAIT ISLANDER** ☐ **BOTH** ☐ **NONE** ☐

MEDICARE NUMBER __ __ __ __ __ __ __ __ __ __ EXPIRY __ __ / __ __

REFERENCE NO. ON THE CARD _____

HEALTHCARE CARD OR PENSION CONCESSION CARD: YES / NO **Type of Card** _____

CARD No: _____EXPIRY DATE: _____

EMERGENCY CONTACT:

NAME _____

RELATIONSHIP _____ PHONE _____

NEXT Of KIN: (If same as Emergency contact write as above)

NAME _____

RELATIONSHIP _____ PHONE _____

Allergies to Medication: Yes/ No _____

Please List: _____

Nature of reaction: _____ Severity: Mild/ Moderate/Severe

Other Allergies: _____

Weight Kg: _____ **Height Cm**: _____

Do you smoke? Yes / No Number per day: _____ Ex Smoker: Yes/No Year quit _____

Do you drink alcohol? Yes/ No How many days per week _____ No. of drinks per day _____

Please list any medical conditions: _____

_____

15/1647 Burwood Highway Belgrave VIC 3160
Phone: 03 9752 6111 Fax: 03 8678 1126
Website: https://www.hillscenemedicalcentre.com.au
Email: admin@hillscenemedicalcentre.com.au

List current medication: _____

_____

Family History: Unknown

Mother still living: Yes/ No - Age at Death _____ Cause of death _____

Any history of: Diabetes / Heart Disease / Stroke / Cancer – Type of Cancer _____

Father still living: Yes/No - Age at death _____Cause of death _____

Any history of: Diabetes / Heart Disease / Stroke / Cancer – Type of cancer _____

_____

PRIVACY STATEMENT By signing below, you (as patient/parent/guardian) are consenting to your personal information, to be used or disclosed for the following purposes:
The diagnosis and treatment of any health condition, including the communication of relevant information only to practice staff, follow up notices for treatment and preventative healthcare, and national / state reminder system registry such as pap smear, immunization, etc.
For legal related disclosure as required by a court of law and disease notification as required by law
For use when seeking treatment by other doctors in the practice or when referred to other health practitioners
I give my permission for my personal health information to be collected, used, and disclosed as above. I understand that only the relevant personal health information will be provided to allow the above actions to be undertaken and I am free to alter or restrict my consent at any time by notifying the practice in writing.

PATIENT / PARENT / GUARDIAN SIGNATURE_____ DATE _____

How did you find out about Hillscene Family Medical Centre? (Please indicate)

Advertisement – Newspaper / Online / Online Search – Google / Health Engine / Walking / Driving Past Recommendation from Friend / Family / Other

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