



**PATIENT DETAILS**

Surname  Given Name/s

Preferred Name  Title: *Mr Mrs Miss Ms*

Marital Status: *Married Divorced Widowed Single* Gender *Male Female Other Unknown*

Address  Postcode

Telephone: *Home*  *Mobile*  Date of Birth

Email Address:

Referral: *Where did you hear about us?*

Ethnicity\*  ATSI Status\* *Aboriginal Torres Straight Islander*

Religion  Occupation:

Medicare Card: *No*  *Ref*  *Expiry*

Veterans Affairs No:  *Gold White* *Expiry*

Commonwealth Seniors Card No:  *Expiry*

Pension Card No:  *Expiry*

Health Care Card No:  *Expiry*

Head of Family/Account Holder: *Name*  *Date of Birth*   
*(if different from above)*  
*Address*  *Postcode*   
*Medicare No*  *Ref*  *Expiry*

Next of Kin: *Name*  *Relationship to Patient*   
*Phone*  *Mobile*

Emergency Contact: *Name*  *Phone*

**CONSENT**

I understand that Woodvale Park Medical Centre needs to collect information for the primary purpose of providing quality health care to properly assess, diagnose and treat my health care needs. The above information can be used by Woodvale Park Medical Centre in the following ways:

- Collect, use and store personal details;
- Release of relevant personal information to other health professionals to allow quality medical care (eg specialist, pathologist);
- Inclusion in a recall reminder register to be advised of follow-up visits and health information;
- Release of relevant personal information to my (prospective) employer, their authorized representative and their insurer in the case of a work related consultation or service; or
- Uploading of health summaries for immunisation, new medications etc to your personal eHealth record.

Signature ..... Date

*\* Please complete these fields even if known*

## IMPORTANT INFORMATION

Please ensure that you provide true and thorough information for doctors.

### Are you Allergic?

Allergic to: *(drug name, food, other)*

Nature of Reaction



Other Info

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### Family Health History

**MOTHER:**

Alive  Yes  No  Age at Death  Cause of Death

*Diabetes    Hypertension    Heart Disease    Stroke    Breast Cancer    Colon Cancer    Depression*  
*(check all that apply)*

**FATHER:**

Alive  Yes  No  Age at Death  Cause of Death

*Diabetes    Hypertension    Heart Disease    Stroke    Breast Cancer    Colon Cancer    Depression*  
*(check all that apply)*

### Alcohol Intake

None  Rare  Occasional  Daily  Standard drinks per day  Drinking days per week

Other information

### Smoking History

Have you ever smoked? Yes  No  Amount per day

Year Started  Year Stopped  Other info

Signature .....

Date



**WOODVALE PARK  
MEDICAL CENTRE**