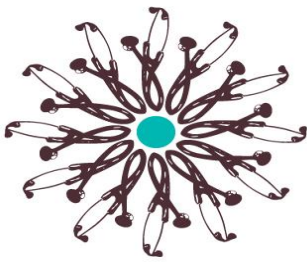


We are committed to providing our patients with the best care.

To do this it is essential that your health record is kept up to date and accurate.

Title (please circle)	Dr	Mr	Mrs	Ms	Miss	Mast	Other:
Pronouns (please circle)	She/Her		He/Him		They/Them		Other:
First Name						Preferred Name:	
Surname							
Date of Birth							
Street Address							
Suburb and Post Code							
Mobile Phone No.							
Home Phone No.						Work Phone No.	
Email Address							
Consent Our Practice uses a reminder system to help maintain your health. The Practice sends reminders by telephone, SMS and post for procedures such as vaccinations, cervical screening and other health reviews.					I consent to being contacted with reminders to help me maintain my health <input type="checkbox"/> Yes <input type="checkbox"/> No		
Our practice also sends information to the Australian Immunisation Register and Cervical Screening Register. These Registers also send reminders, which can be helpful if you move address.					I consent to being contacted with reminders to help me maintain my health <input type="checkbox"/> Yes <input type="checkbox"/> No		
Australian Medicare	<i>Number:</i>		<i>Ref:</i>		<i>Expiry Date:</i>		
Centrelink Concession Card	<i>Number:</i>		<i>Expiry Date:</i>				
OSHC Number (Allianz Students only)	<i>Number:</i>		<i>Expiry Date:</i>				
DVA <input type="checkbox"/> Gold <input type="checkbox"/> White	<i>Number:</i>		<i>Expiry Date:</i>				
Have you ever served in the Australian Defence Force?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, are you a current or ex serving member? <input type="checkbox"/> Current <input type="checkbox"/> Ex				
Cultural background You must complete this section – please identify your cultural ethnicity. Knowing your cultural background can help us provide healthcare that meets your individual needs.	Are you of Aboriginal or Torres Strait Islander origin? <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> No, other cultural background (eg Greek, Chinese, Indian) Please state: _____ Country of birth: _____ Is English your first language? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, do you require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____						
Next of Kin	Name:			Relationship:			
	Mobile or Home No:						
Emergency Contact Person (if different to Next of Kin)	Name:			Relationship:			
	Mobile or Home No:						
PLEASE TURN OVER AND CONTINUE							



Please list any family members that also attend this Practice	Name: _____ Relationship: _____
	Name: _____ Relationship: _____
	Name: _____ Relationship: _____

Employer Name	
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PATIENT PRIVACY

The personal health information that you provide during your consultation and subsequent treatment will be used for the purposes of providing you with high quality health care. Our policy is to protect your privacy and accordingly the information you provide will only be disclosed to other members of our multi-disciplinary team at Adelaide Health Care. This includes our doctors, practice nurses and clinical pharmacist. It will be disclosed to other organisations where required by law. Your contact details may be disclosed for billing or debt recovery purposes.

Adelaide Health Care uses patient health information to assist in improving the quality of care we give to all our patients. Your information held by the practice may be used in research projects to improve healthcare in the community; however, this information will not include data that can identify you.

A copy of our full Patient Privacy Policy is available on our website or at reception. If you have any concerns about the way we manage your health information, please let us know. In the first instance this can be done by contacting the Practice Manager or your doctor. If you are still dissatisfied, you can contact the Federal Privacy Commissioner at:

Office of the Australian Information Commissioner (OAIC)
 GPO Box 5218
 SYDNEY NSW 2001

Website: www.oaic.gov.au
 Privacy Hotline: 1300 363 922

PAYMENT

You understand that payment of all accounts is your responsibility.

You will be charged a fee if you do not attend your appointment without providing a minimum of four hours' notice. All accounts, other than accounts which are bulk billed to Medicare or which are billed to other Third Party payers, are payable in full at the time of treatment. For your convenience we can accept Cash, EFTPOS or Credit Card.

You understand that in the event that accounts which are bulk billed to Medicare or which are billed to other Third Party payers are not honoured by such payers then payment of such accounts is your responsibility.

You also undertake to pay any debt collection and legal costs that may be incurred by Adelaide Health Care as a result of late payment or non-payment of accounts.

Thank you for providing this information, which will assist in your health care.

Please answer: We would like to know – how did you hear about our practice?					
Friend	Relative	Adel Health Care Website	Online Booking	White Pages	Yellow Pages
Hospital	Chemist	Allied Health	Another Doctor	Works Nearby	Work Nearby
Fridge Magnet	Walk in	Google	Facebook	Backpackers	Hotel
Other (please specify):					

DATE: _____ **SIGNATURE:** _____

PATIENT HEALTH DETAILS

All information will be kept confidential

Please complete and give to your Doctor at your appointment.

Your name please: _____ Occupation: _____

Your health history - do you have or have you had a history of?

Operations

Specify: _____

Asthma

Diabetes

Heart disease

Stroke

High blood pressure

Mental Health Problems

Other

Specify: _____

Current medications (including over the counter medications, vitamins and minerals):

Do you have any allergies or are you sensitive to any drugs or dressings? If so, what reaction have you experienced?

Do you have an advance care directive for end of life care? Yes No

For more information please speak to a Nurse or your GP.

Immunisations:

Did you receive all the schedule/recommended vaccinations which were offered as a child and in high school? Yes No

When was the last time you received a vaccination for:

COVID Vaccination Date: _____ not sure / never

Flu Date: _____ not sure / never

Pneumonia Date: _____ not sure / never
(if you are 65 or over)

HPV Date: _____ not sure / never
(Gardasil)

Tetanus Date: _____ not sure / never

Whooping Cough Date: _____ not sure / never
(pertussis)

Family history - have any members of your family had:

Diabetes

Specify: _____

Asthma

Specify: _____

Heart Disease/high blood pressure/stroke

Specify: _____

Mental illness

Specify: _____

Cancer

Specify: _____

Social history

Have you ever smoked?

Yes No

Are you a current smoker?

Yes No

Do you drink alcohol?

Yes No

Are you a drug user?

Yes No Type & frequency _____

When was your last:

Blood pressure check?

within last 12 months 1-2 years ago not sure

Blood test for cholesterol?

within last 12 months 1-2 years ago not sure

Weight/BMI check?

within last 12 months 1-2 years ago not sure

Females

When did you last have:

Pap smear:

Date: _____ **not sure / never**

Breast Check

Date: _____ **not sure / never**

Males

When did you last have:

Prostate check: within last 12 months 1-2 years ago 3-5 years ago never