ADULTS 16+ YEARS

adelaide health care

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.
Could you please assist us by completing the following, thank you

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 ☐ Yes ☐ 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 ☐ Yes ☐ No

Australian Medicare	*Number:*	*Ref:*	*Expiry Date:*
Centrelink Concession Card	*Number:*		*Expiry Date:*
OSHC Number(Allianz Students only)	*Number:*		*Expiry Date:*
DVA ☐ Gold ☐ White	*Number:*		*Expiry Date:*
Have you ever served in the Australian Defence Force?	☐ Yes ☐ No If yes, are you a current or ex serving member? ☐ **Current** ☐ **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? ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No, other cultural background (eg Greek, Chinese, Indian) Please state: _____ Country of birth: _____ Is English your first language? ☐ Yes ☐ No If not, do you require an interpreter? ☐ Yes ☐ 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

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

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: _____
first name *last name*

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