**ST ALBANS MEDICAL SERVICES**

**264 MAIN ROAD EAST, ST. ALBANS**

**PH NO. 9367 1122**

[**www.stalbansmed.com.au**](http://www.stalbansmed.com.au) **Email: info@stalbansmed.com.au**

**PATIENT FORM**

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:**

**Dr Mr Mrs Miss Ms**

|  |
| --- |
|  |

First name\*

|  |
| --- |
|  |

Surname\*

|  |
| --- |
|  |

Date of Birth\*

|  |
| --- |
|  |

Email\*

|  |
| --- |
|  |

Phone Number\*

|  |
| --- |
|  |

Mobile Phone Number

|  |
| --- |
|  |

Work Phone Number

|  |
| --- |
|  |

Street Address\*

|  |
| --- |
|  |

Suburb\*

|  |
| --- |
|  |

Postcode\*

|  |
| --- |
|  |

State\*

|  |
| --- |
|  |

Mailing Address

|  |
| --- |
| **REF:** |

Medicare Number

Make sure you include 10 digits plus the reference number next to your name

|  |
| --- |
|  |

Medicare Expiry Date

**Pension Card and Health Care Card Holders**

DVA Gold Card Number  DVA White Card Number

|  |
| --- |
|  |

Pension Card Number

|  |
| --- |
|  |

Health care Card Number

|  |
| --- |
|  |

Expiry Date on Card

|  |
| --- |
| Name: Relationship: |

**Next of Kin**

|  |
| --- |
| Home: Mobile |

Telephone number

|  |
| --- |
| Name: Relationship: |

|  |
| --- |
| Home: Mobile |

**Emergency**

**Personal Information**

Are you of Aboriginal or Torres Strait Islander origin?\* Yes No

|  |
| --- |
|  |

If no, what is your ethnicity?

Do you require an interpreter if yes what language Yes No

|  |
| --- |
|  |

|  |
| --- |
| Asthma  Diabetes  Hypertension (high blood pressure)  Chronic illness  Operations  Other health problems |

Do you currently have / have you ever had:

|  |
| --- |
|  |

Please list any allergies or sensitivities to

Medications or dressings:

|  |
| --- |
|  |

**Current Medications**

Please list any prescribed medications

You are currently taking:

|  |
| --- |
|  |

Please list any over-the-counter

Medications you are currently taking:

**Family Medical History**

Have any members of your family had: (please elaborate)

* Heart Disease
* Asthma
* Diabetes
* Mental Illness
* Cancer

**Previous Healthcare Provider**

|  |
| --- |
| Name: |

**Please list.**

|  |
| --- |
| Phone: Fax: |

**Do any of you family members attend this clinic?**

**Who referred you or how did you hear about our clinic?**

**Do you consent to receive SMS message as an Appointment Reminder 󠆜 □ Yes □ No**

I understand the information I have given today is correct to the best of my knowledge. I understand that this information will be held in confidence and it is my responsibility to inform the clinic of any changes in my medical status.

**Patient full Name Patient signature**

**---------------------------------------- ---------------------------------------**

**Date: ……/……/…….**

**Doctor’s Signature**

**-------------------------------------**

Consent for use of information.

I confirm that the information I have given (New Patient Form) is correct. I consent to sharing of all relevant information between the general practitioners, specialists, nurse practitioners, nurses, allied health providers and non-clinical staff for the purpose of managing my health. I understand this information will be used to fulfil their duties in the course of planning and managing my health care.