PATIENT INFORMATION SHEET

Title	☐ Mr	☐ Mrs	☐ Ms	☐ Miss	☐ Master

Surname (Apellido)	First Name (Nombre)

Date of Birth (Fecha de Nacimiento)			Gender (Sexo)		
Date	Month	Year	Male (Hombre) ☐	Female (Mujer) ☐	Other: ☐

Street Address (Direccion)	Suburb (Suburbio)	Post Code

Home Phone (Telefono Casa)	Work Phone (Telefono Trabajo)	Mobile Phone (Mobil)

Country of Birth (Pais de Nacimiento)	Occupation (Ocupacion)

Email:

Aboriginal / Torres Strait Islander	☐ Yes	☐ No

Tabacco (Tabaco)	Alcohol (Alcohol)	Allergies (Alergias)
____day / week or Ceased Smoking - year ____________	________ day / week / month (circle the one applicable)	

Medicare Number	Ref:	Valid To		
		Date	Month	Year

Pensioner Concesion Cad Number	Expiry Date		
CRN:	Date	Month	Year

Health Care Card Number	Expiry Date		
CRN:	Date	Month	Year

Bupa Membership	Expiry Date		
N:	Date	Month	Year

Next of Kin (Nombre Pariente cercano)	Relationship (Parentesco)	Phone Number (Numero telefonico)
Emergency Contact (Contacto de Emergencia)	Relationship (Parentesco)	Phone Number (Numero telefonico)

<u>Reminder / Recall Systems:</u> Our practice provides our patients with preventive care and early case detection reminders /recalls e.g. immunisations, annual health checks, skin checks and pap smears.The practice will contact you for all reminders and recalls.

Do you wish to have any relevant health reminders sent to you? ☐ Yes – SMS ☐ No

<u>PRIVACY / CONFIDENTIALITY</u>

Your personal health information and your medical record may be collected, used and disclosed for communicating relevant information with other treating doctors, specialists or health professionals.

Su información medica personal y su registro medico pueden recopilarse, utilizarse y divulgarse para comunicar información relevante con otros medicos tratantes, especialistas o profesionales de la salud.

I , ____ consent to Salud Medical Centre's clinical staff to access and use my health records as part of my medical care.

Yo , ____ doy permiso a Salud Medical Centre para acceder y usar mi historia como parte de mi cuidado medico.

Patients signature:____ Date: ________________________________