HealthSense
MEDICAL CENTRE

DRIVERS LICENSE OR PHOTO ID IS REQUIRED

Patient Detail Form (please complete both sides)

☐Mr ☐Master ☐ Mrs ☐ Ms ☐ Miss ☐ Other

Surname: ______________________ Given Name: _____________________ Middle Name: ______________________

Preferred Name:

Date of Birth: ________/________/________ Ethnicity: (other than Australian) ______________________

Birth Sex: ☐ Female ☐ Male ☐ Other ☐ Unknown

Gender Identity: ☐ Female ☐ Male ☐ Non-Binary ☐ Gender Diverse ☐ Transgender ☐ Different Identity

Pronouns: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs

☐ Australian ☐ Aboriginal ☐ Torres Strait Islander **Occupation:**..

Street Address: ________________________________ City/Suburb: ______________________ Postcode: ________

____

Home Phone: Mobile: Work Phone: E-mail:

Medicare Number: **Ref No: (Next to Name)** **Expiry Date: (Bottom Right Corner)**

How would you like your reminders sent: ☐ Phone / Mobile ☐ Post ☐ SMS

☐ Health Care Card No: ______________ Expiry Date: ________ ☐ Pension Card No: ______________ Expiry Date: ________

☐ Department of Veteran Affairs Card Number: ______________________________ Expiry Date: __________________

Health Insurance Fund: _______________ Membership No: ____________________

EMERGENCY CONTACT: I authorise the following person to be contacted in the case of an emergency:

Name: ______________________ Relationship: ____________________ Contact No: ____________________

NEXT OF KIN:

Name: ______________________ Relationship: ____________________ Contact No: ____________________

Family: ☐ Unknown (eg Adopted) ☐ No Significant Family History

Mother Alive ☐ Yes ☐ No Age of Death: ___________ Cause of Death ______________________

Father Alive ☐ Yes ☐ No Age of Death: ___________ Cause of Death ______________________

Significant Family History:

Mother: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression ☐ Breast Cancer

Father: ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐ Depression

Marital Status ☐ Single ☐ Married ☐ De Facto

Elite Athlete ☐ Yes ☐ No

Breast Feeding ☐ Yes ☐ No

Do you have any allergies: ☐ Yes (Please List) ☐ No

____

Do you use any of the following: Past Alcohol Intake: ☐ Nil ☐ Occasional ☐ Moderate ☐ Heavy

Alcohol ☐ No. ☐ Yes Days per week ______ Standard drinks per day ______ Year Started: _____ Year Stopped: _____

Smoker ☐ No. ☐ Yes How many per day _______ Year Started ___________ ☐ Ex-Smoker Ceased: _______

How did you get to know about us? ☐ Google ☐ Website ☐ Facebook ☐ Health Engine/HotDocs

☐ Letterbox/Leaflet/Magnet ☐ Walk In ☐ Word of Mouth ☐ Chemist

☐ Other...

PLEASE SIGN ON REVERSE SIDE ☐ Driver's License Sighted

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Privacy Statement

Your Personal Health Information and your Medical Records may be collected, used and disclosed, including but not limited to the following reasons:

- **For Communicating relevant information with other treating doctors, specialists or allied health professionals**
- **For follow up reminders/recall notices**
- **For disease notification as required by law (e.g. infectious diseases)**
- **For use by all doctors across both Golden Grove & Fairview Green locations, when consulting with you**
- **For research purposes (de-identified, meaning you are not able to be identified from the information given)**
- **For obtaining previous pathology and radiology results.**
- **For Uploading Information onto your personal 'My health Record'.**

If you have any concerns or wish to restrict access to your personal health information, please discuss these with your doctor.

Signature: ____ Date: _________________________