North Beach Medical Centre
Patient Form

Title Surname Given names

Date of birth / / ☐ Female Country of Birth

Marital status: ☐ Single ☐Married ☐Defacto ☐Divorced ☐ Widowed

Medicare number rank number expiry date /

Pension, Health Care Card, or Veterans Affairs number expiry date /

Home address postcode

Postal address

Phone(home) (work) (mobile)

Email Occupation:

Next of Kin Name Relationship to you

NOK Phone (home) (work) (mobile)

Emergency Contact Name Phone (Home) (Mobile)

Are you of aboriginal or Torres Strait Islander origin? ☐No ☐Aboriginal ☐Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

List allergies and intolerances to medications

List regular medications and doses including non prescription medications such as vitamins

Patients between the ages of 18 and 70 please indicate when you had your last Pap Smear

We would like to be able to remind you of appointments and upcoming health checks by telephone, email and SMS. If you do not wish to have these reminders please tick the No box. ☐ No

I consent to my health records being reviewed as part of the quality improvement activities and am happy to have my details added to national and state health prevention programs. ☐ Yes ☐ No

If you are happy to have reminders and have the practice contact you by the follow methods please indicate ☐ Yes ☐ SMS ☐ Telephone message on home phone ☐ Email ☐Letter

Signature (parent or guardian) Date / /2013

TRANSFER OR HEALTH INFORMATION You may have consulted with GP at another practice. The health information held by that GP may assist us with your future health care. You may wish to have copy or summary of your health records transferred to this practice. Please ask the receptionist for information about how this can take place.

(M) Reviewed 26/1/13