|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title:** | | | | Mr Mrs Ms Master Miss Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
| **First Name :** | | | | *As it appears on Medicare Card* | | | | | | | | | | **Last Name:** | | | *As it appears on Medicare Card* | | | | | | | | |
| **Date of Birth:** | | | |  | | | | | | | | | | **Gender:** | | | Male Female Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Marital Status:** | | | | Married Single Separated Divorced Defacto Widowed | | | | | | | | | | | | | | | | | | | | | |
| **Street Address:** | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | Postcode: | | |  |
| **Postal Address:** | | | | as above | | |  | | | | | | | | | | | | | | | | | | |
| **Contact Number:** | | | | **Mobile:** | | |  | | | | | | | | | **Home:** | |  | | | | | **Work:** | |  |
| **Consent to Appointment reminders/recall reminders via SMS/Text Message:** | | | | | | | | | | | | | | | | | | | | | | | Yes No | | |
| **Occupation:** | | | |  | | | | | | | | | **Country of Birth** | | | | | |  | | | | | | |
| **Are you Aboriginal or Torres Strait Islander?** | | | | | | | | | | | | No Yes; Aboriginal Yes; Torres Strait Islander | | | | | | | | | | | | | |
| **Other Cultural Background(please list here)*:*** | | | | | | | | | | | |  | | | | | | | | | | | | | |
| **Medicare:** | |  |  | |  |  | |  |  |  |  | | |  |  | **Reference number: (Next To Your Name)** | | | |  | | | **Expiry  date:** |  | |
| **In order to receive bulk-billing services, a valid Medicare Card must be presented at each consultation.** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Centrelink/Concessions/ DVA:** *Please note a valid concession or DVA card must be presented at reception.* | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Centrelink Card:   Pension Healthcare** | | | | | | | *-card number here if applicable -* | | | | | | | | | | | | | | Expiry: | | |  | |
| **DVA Gold White:** | | | | | | | *-card number here if applicable -* | | | | | | | | | | | | | | Expiry: | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Next of Kin:** | | | | Full Name: | | | | | | | | | | | | | | | | | Phone : | | | | |
| Relationship to you: | | | | | | | | | | | | | | | | | Phone 2:  *optional* | | | | |
| **Emergency Contact:**    as above | | | | Full Name: | | | | | | | | | | | | | | | | | Phone : | | | | |
| Relationship to you: | | | | | | | | | | | | | | | | | Phone 2:  *optional* | | | | |
| **Health Information** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Alcohol:** | No Yes: How Many \_\_\_\_\_\_\_\_\_\_Day / \_\_\_\_\_\_\_\_\_\_ Week / \_\_\_\_\_\_\_\_\_\_ Month | | | | | | | | | | | | | | | | | | | | | | | | |
| **Smoking:** | No Ceased Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes: How Many \_\_\_\_\_\_\_\_\_\_Day / \_\_\_\_\_\_\_\_\_\_ Week | | | | | | | | | | | | | | | | | | | | | | | | |
| **Height** |  | | | | | | | | | | | | | | | **Weight** | | |  | | | | | | |
| **Allergies:** | No Yes*(specify allergy and reaction):* | | | | | | | | | | | | | | | | | | | | | | | | |