Family Care GP

Dear Patient. We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate. We Request the following information to complete your files. All information provided will be handled with utmost privacy and confidentiality and will only be used in the delivery of medical care to you.

Title Mr Mrs Ms Miss Mast Other_____

Given Names:

(Preferred name if different:)

Surname:

Date of Birth:

Ethnicity: ☐ Australian ☐ Aboriginal ☐ Torres Strait Islander ☐ Other – Please list:

Is English your first language? Yes/No If not do you require an interpreter? Yes/No

Please specify language: _____

Street Address:

Suburb & Postcode:

Phone: (Home) (Mobile)

Do you consent to receive SMS reminders and recalls? Yes/No

Email:

Medicare Card/Veterans Affairs (White/Gold) _ _ _ _ _ _ _ _ _ _ REF NO: _ EXPIRY DATE: __ /__

If you are unable to present a current MEDICARE CARD we require PHOTO ID or you may have to pay the practice fee

☐ Health Care Card ☐ Pension Card CRN: Expiry: __ / __

Next of Kin *Person will we are able to contact if needed*	Name: Relationship to you: Contact Ph no:
Emergency *(Person will we are able to contact if needed)*	¨Same as above Name: Relationship to you: Contact Ph no:
Employment Status:	☐ Retired ☐ Unemployed ☐ Student ☐ Pensioner ☐ Infant ☐ Home duties ☐ Employed – Please list occupation _____
Allergies:	☐ No ☐ Yes – Name and reaction _____
Smoking Status:	☐ Non-Smoker ☐ Ex-Smoker ☐ Current Smoker à Cigarettes per day ___
Alcohol Status:	☐ Non-Drinker ☐ Occasional ☐ Yes - Days per week ___ Std drinks per day___
Marital Status:	☐ Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed
Living arrangements:	☐ Own home ☐ Renting ☐ Aged care facility ☐ Hostel ☐ Other
Lives with:	☐ Spouse ☐ Relative(s) ☐ Friend(s) ☐ Alone
Carer:	Do you have a Carer: ☐ No ☐ Yes Are you a Carer: ☐ No ☐ Yes
Significant Family History	☐ No significant family history ☐ Unknown (e.g. adopted)
Mother:	☐Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐Depression ☐Breast Cancer ☐ Other_____ Mother Alive: ☐ Yes ☐ No – Cause of Death? _____ (if known)
Father	☐Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Colon Cancer ☐Depression ☐ Other_____ Father Alive: ☐ Yes ☐ No Cause of Death? _____(if known)

I consent to this practice, transferring this information to other Health Providers for the purpose of my ongoing medical management, or for use in Practice Enhancement Activities (Information will be de-identified wherever possible when use for Practice Enhancement.

Patient signature: _____ Date: _____

(if patient is under 14 years – parent or guardian must sign their name)