

Title: Mr Mrs Miss Ms

Surname: _____

Given Names: _____

Date of Birth: / / Sex: Male Female



Shop2/23 Denham Street Rockhampton Qld 4700
Telephone: 49 224 126 Facsimile: 49 227 536

Marital Status: Married Single Divorced Separated Widowed Defacto

Ethnicity Aboriginal Torres Strait Islander Both Non ATSI Other _____
Do you require a translator? Yes No

Administration Details

Residential Address: _____

Postal Address: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Medicare Number: _____

Reference No: _____ Expiry Date: ____ / ____ / ____

Concession Details:

Yes No Please Circle: Health Care Card / Pension / Veteran Affairs Card No
Number on Concession Card: _____ Expiry: ____ / ____ / ____

Private Health Fund:

Fund: _____

Membership No: _____

Email Address: _____

Occupation: _____

Employer: _____

Allergies:

Nil Known Yes

Details: _____

Next of Kin:

Name: _____

Phone: _____

Relationship: _____

Emergency Contact:

Name: _____

Phone: _____

Relationship: _____

Access to Medical Records

Authorisation:
(Family member or partner to ring for results etc on your behalf)

I give permission for _____, DOB: ____ / ____ / ____, to obtain full access to my medical records. ie. Ring for results or check on appointments etc. This is required if you wish for someone else (eg. Family member, partner) to be able to ring for results etc. **This applies for all people aged 16 years and over. If this authorisation changes, it is the responsibility of you, the patient, to contact us and amend this authorisation.**

Consent:

By signing this form I agree to the following:

- I authorise the practice to obtain copies of any medical information about me from/send copies of any medical information about me to (delete whichever does not apply) other health professionals as required.
- I understand that any information provided by me will be confidential.
- I am aware that **City Heart Medical is not a BULK BILLING PRACTICE** and I agree to pay all fees charged by the practice.
- I agree to pay all costs associated with the collection of overdue or unpaid accounts including a late payment fee.
- **I consent to be contacted by SMS or Email for all clinical reminders and communication.**

Signature :

Date: ____ / ____ / ____

CITY HEART MEDICAL -

CLINICAL INFORMATION UPDATE

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. Please advise your Doctor of any changes that have been made to your medications that he/she may not be aware of and any over the counter medications you may take (e.g. vitamins, sports supplements etc). This information is very important to enable you to receive the best outcomes for your health. Thank you for taking the time to complete these questions - it is appreciated.

Could you please assist us by completing the following:

PATIENT NAME: _____

DATE OF BIRTH: _____

Ethnicity: Aboriginal Torres Strait Islander Both Non ATSI Other _____

Allergies: Nil Known Yes

Details: _____

Family History: Unknown (e.g Adopted) No significant Family History

Mother alive? Yes No Age at Death _____ Cause of death _____

Father alive? Yes No Age at 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

Alcohol: **Current Alcohol Intake** Non Drinker

Days per week: _____ Standard Drinks per day: _____

Past Alcohol Intake

Nil Occasional Moderate Heavy

Year Started: _____ Year Stopped: _____

Tobacco: **Current Smoking History**

Non Smoker Ex Smoker Smoker

(Please circle) – Cigarettes / Cigars / Pipe

Year Started: _____

Past Smoking History

Light Moderate Heavy

Year Started: _____ Year Stopped: _____