Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐

Surname:_____

Given Names: _____

Date of Birth: / / **Sex**: Male ☐ Female ☐

CITY HEART MEDICAL

'Excellence in General Practice'

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:** _____

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: _____

OFFICE USE ONLY

IDENTIFICATION SIGHTED: .....

WITNESSED BY: .....

SIGNATURE: .....

INITIALS: .....