



CHANCELLOR PARK
FAMILY MEDICAL PRACTICE

Patient's Full Name: (Mr Mrs Ms Miss Mst) _____ Male/Female

Date of Birth ____/____/____ Ph: _____ Wk: _____ Mob: _____

Residential Address

Street: _____ Suburb: _____ Postcode: _____
(Number & Name)

Postal Address if different from above

PO Box: _____ Suburb: _____ Postcode: _____

I wish to receive e-mail reminders or newsletters in the future, by providing my e-mail address I am consenting to this use.

My e-mail address is _____

Please write clearly & in the appropriate case UPPER or lower.

Private Hospital insurance Yes/No Basic Hospital Intermediate Top Hospital

Do you require a translator Yes/No Preferred Language _____?

Emergency contact full name: _____ Relationship: _____ Ph: _____

If we need to contact you with results or to change an appointment, how would you prefer we do this?

(Home Phone, Work Phone, Mobile, Letter) Other _____ **Preferred number** _____

Do you authorise messages to be left for you at this number where the surgery is identified as the caller? YES/NO

How did you choose this surgery? (Location, Yellow Pages, referred by friend/relative) Other _____

Person responsible for account (who will pay) e.g. Self _____

Payer's Address (if different from above) _____ Phone: _____

It is the policy of this practice that all accounts are paid at the time of consultation; EFTPOS is available

Medical History

PLEASE CIRCLE – PLEASE ANSWER ALL QUESTIONS

Aboriginal or Torres Strait Islander Yes/No

Pension/Health Care Card Yes/No

Smoker Yes/No Number of cigarettes/day _____

Current Medications Yes/No Please list _____

Allergies Yes/No Please list _____

***Please make sure you tell the Doctor about any allergies you may have or any medications you are taking, including vitamins**

PTO

Medical History cont.

Has the patient ever had problems with:

Blood pressure	yes/no	Date _____
Cholesterol	yes/no	Date _____
Blood glucose	yes/no	Date _____
Diabetes	yes/no	Date _____
Heart ailments	yes/no	Date _____
Asthma	yes/no	Date _____

Please include an approximate date or time frame where possible.

Has anyone in the patient's family had:

Heart problems	yes/no _____ (details)
Stroke	yes/no _____ (details)
Diabetes mellitus	yes/no _____ (details)

Relationship i.e. Mother, Father,
Brother, Sister

Your Privacy , Our Concern

In accordance with the *Privacy Act (1988)*, all information collected in this practice is treated as "sensitive information". To protect your privacy, this practice operates in accordance with the Act.

We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone number etc.

Selected information may be disclosed to various other health services involved in supporting your health care management, (e.g. Pathology & Radiology)

If you have questions about how we handle your personal health information or need to arrange access to your records, please ask the staff or your doctor, as appropriate.

Please Note - Due to privacy laws it is preferred that adults and over sixteens arrange their own appointments whenever possible. Results **can not** be given to a third party except under special circumstances.

I understand and consent to the above.

Signature _____ Date ____/____/____.

OFFICE USE ONLY:

Information form given to patient

Patient signature