

**Details Update/Enrolment Permission**

**Patient Information**

Mr Mrs Ms Miss Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_

Contact Number/s: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

Marital Status: Single Married Divorced Widowed De facto

Do you identify as Aboriginal? Yes No Other Ethnic Background: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you identity as Torres Strait Islander? Yes No Country of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ref: \_\_\_\_ Expiry date: \_\_\_/\_\_\_/\_\_\_\_\_

HCC/Pension Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry date: \_\_\_/\_\_\_/\_\_\_\_\_

Do you consent to our practice contacting you via SMS? Yes No Best number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consent to our practice contacting you via email? Yes No Best email to contact you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any known allergies and your reactions or put none known if none: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social history**

Have you ever smoked? Yes No If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes No If yes, how much do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many days per week do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient History**

Have you ever had: Diabetes Kidney disease Asthma High blood pressure

Breast cancer Colon cancer Stroke Depression

Epilepsy Other cancer Heart disease

Please list any operations or previous illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Female patients: Please provide the date of your last pap smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family history:**  Unknown No significant history Other (see list below)

**Mother:** Diabetes Kidney disease Asthma High blood pressure

Breast cancer Colon cancer Stroke Depression

Epilepsy Other cancer Heart disease

**Father:** Diabetes Kidney disease Asthma High blood pressure

Breast cancer Colon cancer Stroke Depression

Epilepsy Other cancer Heart disease

**Next of kin**

Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number(s): Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If the person you would like us to contact in an emergency is not your next of kin, please advise their details:

**Emergency contact**

Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number(s): Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give my consent for my personal and medical information to be used for the following purposes:

* Follow up reminder/recall notices for treatment and preventative healthcare
* For accounting procedures and the collection of professional fees
* The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
* Accreditation and quality assurance activities are conducted b professionally trained non-treating GP’s and other trained and qualified persons eg. General Practice Managers
* For legal related disclosure as required by a court of law
* To allow medical students and staff to participate in medical training/teaching using only d-identified information
* For disease notifications required by law
* For use when seeking treatment by other doctors in this practice

I understand that only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying the practice in writing.

I agree that de-identified data (anonymous details) can be used by my doctor for research

I understand that no data identifying me will be used.

Agree Disagree

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_