BALWYN ROAD FAMILY MEDICAL CENTRE

FIRST NAME		SURNAME		M/F/OTH
ADDRESS			DOB:	
SUBURB			POSTCODE:	
HM PH:		MOBILE		WRK PH:
Medicare card Number:		REF:	EXP:	
Health Care Card Number/Type			EXP:	
EMAIL ADDRESS:				
OCCUPATION:		RETIRED	YES	NO
Country Of Birth				
Are you of Aboriginal decent?	YES NO	Are you Torres Strait Islander:	YES	NO
IS YOUR VIST UNDER WORKCOVER:	YES NO	IS YOUR VISIT UNDER TAC :	YES	NO
ARE YOU ALLERGIC TO ANY MEDICATION?IF YES PLEASE LIST BELOW				
MEDICATIONS:		REACTIONS:		
EMERGENCY CONTACT NAME:				
EMERGENCY CONTACT ADDRESS:				
EMERGENCY CONTACT PH:		RELATIONSHIP:		
ARE YOU A SMOKER? YES NO IF YES HOW MANY SMOKES A DAY?				
IF YOU HAVE QUIT SMOKING WHEN DID YOU QUIT SMOKING:				
MARITAL STATUS: SINGLE MARRIED DEFACTO DIVORCED WIDOW				
FAMILY HISTORY: ANY KNOWN FAMILY MEDICAL HISTORY? IF YES PLEASE LIST				
MEDICAL CONDITION:				
MOTHER			ALIVE	YES/NO
FATHER			ALIVE	YES/NO

Privacy Agreement & Patient Consent:

I understand that Balwyn Road Family Medical Centre and associated Medical Centres comply with the privacy Act (1988) and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have read the above and consent to Balwyn Road Family Medical Centre collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits; inclusion in national/state reminder systems/registers, medical updates and health information and the release of relevant personal information to my (prospective) employer, their authorised representative and their insurer in the case of a work related consultation or service. I understand I may withdraw my consent for Balwyn Road Family Medical Centre to use and disclose my personal information (except when legal obligations must be met).

SIGNATURE: DATE: