ST.ALBANS MEDICAL SERVICE
264 MAIN ROAD EAST, ST.ALBANS
PH NO. 9367 1122

**PATIENT FORM**

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.

**Could you please assist us by completing the following:**

| | | |
|---|---|---|
| **Title** | ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss | |
| **Surname** | | |
| **First Name** | | |
| **Date of Birth** | | |
| **Street Address** | | |
| **Suburb and Post Code** | | |
| **Home Phone** | | |
| **Work Phone** | | |
| **Mobile Phone** | | |
| **Email** | | |
| **Please note patients with a current pension or healthcare card are bulk billed. All other patients incur a $60 fee payable on date of service** | | |
| **Medicare Number & Ref** | #: | Expiry: |
| ☐ **DVA Gold** ☐ **DVA White** (Please tick which) | #: | Expiry: |
| **Pension Number** | #: | Expiry: |
| **Health Care Card Number** | #: | Expiry: |
| **Private Health Cover** | Name: | #: |
| **Next of Kin** (Name and Telephone number) | | |
| **Emergency Contact** (Name and Telephone number of the person we can contact if needed) | | |
| **Employer Name** | | |
| **Employer Address** | | |
| **Employer telephone no.** | | |

## Patient Background

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds.

**Do you identify as someone from a culturally and/or linguistic diverse background?**

☐ No

☐ Yes. Please explain:

**To assist with health initiatives – are you of Aboriginal or Torres Strait Islander orgin?**

☐ No

☐ Yes - Aboriginal

☐ Yes - Torres Strait Islander

☐ Yes – Aboriginal & Torres Strait Islander

## Your Health History

**Do you have or have you had a history of the following?** (please explain)

☐ Operations

☐ Asthma

☐ Diabetes

☐ Hypertension

☐ Chronic Illness

☐ Other

**Do you have any allergies or are you sensitive to drugs or dressings?**

☐ No

☐ Yes. Please explain:

## Current Medications

**Please list all current medications including over the counter medications, vitamins and minerals:**

## Family History

**Have any members of your family had:** (please explain)

☐ Heart Disease

☐ Asthma

☐ Diabetes

☐ Mental Illness

☐ Cancer

## Previous Healthcare Provider

**Please list name and contact details of previous doctors.**

**Do any of your family members attend this clinic**

**Who referred you or how did you hear about our clinic**

**My Health Record**

Are you currently registered/or are interested in having a My Health Record? Yes No
Do you consent to our clinic assisting you to register for My Health Record? Yes No