ROMSEY & LANCEFIELD MEDICAL
PATIENT INFORMATION

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast ☐ Dr

Surname:_____ **First Name:**_____

Date of Birth: / /

Postal Address:_____**Town:**_____**Postcode:**_____

Street Address (if different from postal):_____

Day Time Phone:_____ **Mobile:**_____**Work:**_____

Email address:

***Emergency* Contact Person:** **Relationship to you:**

Contact phone number (mobile): **Home:**

***Next of kin* Name & address:** **Relationship to you:**

Contact phone number (mobile): **Home:**

Your cultural identity:

☐ Aboriginal ☐ Torres Strait Islander ☐ Non Indigenous ☐ Other _____

Medicare Number
Ref No. Next to name: **Expiry:** ____/_____/_____

Concession Card Number (Pensioner or Health Care Card)
Expiry: ____/_____/_____

DVA Card Number

☐ **DVA Gold** ☐ **or White Card** **Expiry:** ____/_____/_____

Dependent Children/Other Family Members

Name	Date of birth	Name	Date of birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FEEDBACK

How did you find out about our Medical Centre(s)?

☐ Word of Mouth ☐ White Pages ☐ Yellow Pages
☐ Signage outside practice ☐ Drive / Walked past ☐ Internet
☐ Newsletter ☐ Friends
☐ Pharmacy ☐ Other (please specify) _____

PLEASE TURN OVER AND COMPLETE HEALTH SUMMARY

Do you have any on-going health problems? YES ☐ NO ☐
If yes, please list

_____

_____

_____

Have you had any significant previous health problems? YES ☐ NO ☐

_____

_____

Have you ever had or family history of

Diabetes	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent	☐ No
Heart disease	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent	☐ No
Stroke	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent	☐ No
Asthma	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent	☐ No
Cancer	☐ Mother	☐ Father	☐ Brother/Sister	☐ Grandparent	☐ No

If yes to cancer question, please specify what kind: _____

Please list all medications you currently take; None ☐

_____

_____

Please list any drug, food or other allergies you have; Nil known ☐

_____

Do you smoke?
No ☐ If you are an ex-smoker , when did you stop? ……
Yes ☐ How many per day? ……
Do you consume alcohol?
No ☐
Yes ☐ How many standard drinks per day……. Week……..
Occasionally ☐
Do you take any other recreational substances?
No ☐
Yes ☐ Please detail……
Occasionally ☐

When did you last have these immunizations?
Influenza Date;
Pneumonia Date;
Tetanus Date;

Women's Health
When was your last Pap Smear?
Date if known……
Within last 12 months ☐
Within last 2 years ☐
More than 2 years ago ☐
More than 4 years ago ☐
Never ☐
Not required ☐

Men's Health – if over age 45
When was your last Prostate check?
Date if known……
Within last 12 months ☐
Within last 2 years ☐
More than 2 years ago ☐
More than 4 years ago ☐
Never ☐

Office use only
Date entered ____ / ____ / ____
Name

Romsey Medical

Lancefield Medical

We Care for your Health

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

Romsey Medical & Lancefield Medical Centres collect information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare Australia requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- To contact you or your family for the purposes of Recalls & Reminders

Patient information shall not be released to a third party without the expressed consent of the patient.

I have read the information above and understand the reasons why my information is collected.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above.

Signed _____ Date _____

Name: _____