PATIENT HISTORY FORM

Title:_____ Surname:_____ Given Name:_____

Date of birth:_____ Age:_____ Occupation:_____

Address: _____

Suburb : _____ Postcode: _____

Telephone: (H) _____ (M)_____ (W) _____

Email: _____

Medicare No: | | | | | | | | | | | Patient Reference No: | |

Expiry Date:_____

Health Fund: _____ Membership No.:_____

Health Care Card/Pension No.:_____

Dept of Veteran Affairs No.:_____

Usual GP Name: _____

Medical Conditions:_____

Medication: _____

Allergies: _____

Next of Kin Name:_____ Phone No.:_____

Relationship of next of kin: _____

Patient Consent: In line with the Federal Privacy Act of 21 Dec 2001, our medical practice requires your consent to collect personal information.
This information is essential to help us provide you with the best quality health care possible. In addition this information is used for the following purposes: Administrative, billing, including compliance with health insurance commission requirements. Communication with other medical and allied medical professionals involved in, or who may be deemed necessary in your ongoing care. Also, certain conditions are required by law to be notified to Queensland Health.

I,_____(Print name) have read and understand the terms for the collection of my personal information. I am aware that this information will be handled in line with the Practice's privacy policy. I am obliged to withold any requested information but understand that in so doing, this may compromise the quality of my health care. I am aware of my right to access this information, except in circumstances in which it may be legitimately witheld.

I hereby consent to the collection and handling of my personal information as set

out above _____(Signature) _____(Date)