MITTAGONG MEDICAL CENTRE

Patient Details

Title:	**Today's Date:**
First Name:	
Surname:	
Known As:	
Date of Birth:	
Aboriginal? ☐ **Yes** ☐ **No**	**Torress Strait Islander?** ☐ **Yes** ☐ **No**
Medicare No:	**Number next to Name:**
Expiry Date:	
Health Care/Pension Card? ☐ **Yes** ☐ **No**	
Card No:	**Expiry Date:**
Vet Affairs Card? ☐ **Yes** ☐ **No**	
Card No:	**Expiry Date:**
Can we send you appointment reminders via SMS? Yes/No	
Street Address:	
Town: **State:** **Postcode:**	
Postal Address: (if different from above)	
Home Phone:	
Work Phone:	
Mobile Phone:	
Email:	
Marital Status:	
Occupation:	
Country of Birth:	
Next of Kin:	**Full Name:**
Relationship to You:	**Phone Number:**
Emergancy Contact Details:	**or same as Next of Kin? Yes/No**

Please turn over……

SURNAME:

Allergies:	
1	**2**
3	**4**
Do you drink Alcohol? ☐ **Yes** ☐ **No**	
Do you Smoke? ☐ **Yes** ☐	**How many per day?**

What Medications are you on ?

1	**2**
3	**4**
5	**6**

Current Medical Illness?

1	2
3	4

Past Medical Illness?

1	2
3	4

Past Operation?

1	2
3	4

PATIENT CONSENT:

Privacy and Personal Information

Mittagong Medical Centre use this infomration on this form to assist in managing and planning patients health problems. The collection , storage and release of information provided is protected under the Privacy Act 1988 and Privacy Amendment Act 2012. We are committed to protecting your privacy. Mittagong Medical Centre only give information to someone else where the patient gives permission or , in special circumstances, where Commonwealth Legislation allows or requires it.

Consent For use of Information

I,_____hereby give consent to the Doctors at Mittagong Medical Centre to take a medical record of my consultation. I give permission for the Doctors at Mittagong Medical Centre to exchange any medical imformation with other doctors or medical service proveders who considered necessary for my medical welfare. I understand that I have the right to request my nominated treating doctor NOT release certain information, the details of which will be discussed in confidence with my nominated doctor.

☐ **Tick here if you DO NOT consent to being registered with the Department of Health for a shared electronic health file (my Health record)**

Signature of Patient or Guardian: **Date:**