Patient Information Form

Patient Details:

- **Title:** [Mr./Mast./Mrs./Ms./Miss./Dr.]
- **First Name:**
- **Middle Name:**
- **Last Name:**
- **Preferred Name (if applicable):**
- **Date of Birth:**
- **Birth Sex:** [Male/Female/Other]
- **Gender Identity:** [Male/Female/Non-Binary/Transgender/Other]
- **Pronouns:** [He/Him/She/Her/They/Them/Other]

Contact Information:

- **Home Address:**
- **Postal Address:**
- **Home Phone:**
- **Mobile Phone:**
- **Email:**

Healthcare Information:

- **Medicare Card Number: IRN EXP:**
- **Pension/Health Care Card Number (if applicable): EXP:**
- **DVA (Department of Veterans' Affairs) Number (if applicable):**

Emergency Contacts: Who can we call in an emergency?

- **Next of Kin:**
  - **Name:**
  - **Relationship:**
  - **Phone:**
- **Emergency Contact:**
  - **Name:**
  - **Relationship:**
  - **Phone:**

Additional Information:

- **Occupation: If retired, from what?**
- **Allergies:**
- **Smoking History: Do you smoke? How many a day? Year started?**
- **Alcohol History: Do you drink? How many per day? Days per week?**

- **Family history and Social history: (For your GP)**
- **Is your mother alive**? YES/NO **Cause of death**: **Age at death**:
- **Is your father alive**? YES/NO **Cause of death**: **Age at death**:
- **Any significant family medical history**?

Ie: Stroke, diabetes, heart attack, depression, any cancers, etc (Please specify)

Ethnicity:

- **Please select your ethnicity: (Cultural background)**
  - Australian, non-indigenous
  - Aboriginal but not Torres Strait Islander
  - Both Aboriginal and Torres Strait Islander
  - Torres Strait Islander but not Aboriginal
  - Other (please specify): ___________

Consent and Agreement: I understand that the information provided above will be used to ensure the quality of healthcare services and accreditation purposes. I consent to the collection, storage, and use of this information by the healthcare facility and its authorized personnel. I acknowledge that I have the right to update or correct my information at any time.

Patient Signature: _________________________ **Date:**

Note: Your privacy is important to us. This information will be kept confidential and will be used solely for healthcare and accreditation purposes. If you have any concerns about providing certain information, please discuss them with our staff.
*** IF THE PATIENT UNDER 18 AND IS ON A PARENT/GUARDIAN MEDICARE CARD PLEASE FILL OUT THE FOLLOWING: ***

Parent/Guardian name:

Medicare reference number:

- **DOB:**
- **Relationship:**
- **Phone:**
- **Address if different to patient:**