MUNDARING MEDICAL CENTRE

Patient Demographic / Health Summary

Welcome to Mundaring Medical Centre. We are committed to providing our patients with the best care and to do this, it is essential that your medical records are accurate Please assist us with the completion of the following.

TITLE: DR MR MRS MISS MS **GENDER:** M / F
SURNAME:
FIRST NAME:
MARITAL STATUS: Single / Married / De Facto / Separated / Divorced / Widowed
DATE OF BIRTH:
COUNTRY OF BIRTH:
INDIGENOUS / TORRES STRAIT ISLANDER: YES / NO
PRIMARY LANGUAGE:
OCCUPATION:
ADDRESS:
SUBURB: **STATE:** **P/CODE:**
HOME PHONE: **WORK PHONE:**
MOBILE: **EMAIL:**
MEDICARE NO: ____ **REF:** ____ **EXP:** ___ / ___
CONCESSION CARD NO: ____ **EXP:** ___ / ___
DVA NO:
PRIVATE HEALTH FUND: MEMBER NO:
NAME OF NEXT OF KIN:
PHONE NO:
RELATIONSHIP:

EMERGENCY CONTACT DETAILS (Friend, relative or same as above)

IMMUNISATION – are they up to date:

Tetanus Yes / No Year ________
Hepatitis B Yes / No Year ________
Hepatitis A Yes / No Year ________
Influenza Yes / No Year ________

I provide my consent for Mundaring Medical Centre to collect, use and disclose my personal and health information as outlined in the leaflet provided by the PRIVACY ACT (1988) – Privacy Amendment (Private Sector) Act 2000.

Signature ________
Name ________ Date ________

DO YOU CURRENTLY SMOKE? Yes / No How many cigarettes ________
HAVE YOU EVER TRIED TO QUIT? Yes / No Year ________
HAVE YOU EVER SMOKED? Yes / No

DO YOU DRINK ALCOHOL? Never / Less than monthly / 1-2 days per week / 3-4 days per week / 5-6 days per week / daily

DO YOU DRINK 6 OR MORE STANDARD DRINK ON ONE OCCASION?
Never / Less than monthly / monthly / weekly / daily / almost daily

DOES YOUR ALCOHOL CONSUMPTION CONCERN YOU? Yes / No

CURRENT MEDICATIONS (include over the counter medications and vitamins)
Nil [ ] please tick

ALLERGIES Nil known [ ] please tick
Medications
Food
Other

FAMILY MEDICAL HISTORY – Have any members of your family ever had?
[ ] Diabetes [ ] Heart Disease [ ] Asthma [ ] Cancer
[ ] Mental Illness [ ] Hypertension

PAST MEDICAL HISTORY

Year	Condition

PAST SURGICAL HISTORY

Year	Procedure	Surgeon (if known)

ALL PATIENTS TO READ AND SIGN PRIOR TO THEIR APPOINTMENT

All accounts are payable on the day of consultation.

Declaration

I understand that other patients are waiting for an available appointment. I agree that –

- If I am unable to attend my appointment I will give a minimum of **2 hours** notice of my cancellation.
- If I do not cancel my appointment or fail to attend I may be charged a fee for my missed appointment.
- My account is to be paid on the day of consultation. An administrative fee of 20% will be incurred if accounts are outstanding longer than 90 days and I shall be responsible for all collection fees incurred.

In the event of a Workers' Compensation / Public Liability and Motor Vehicle Accident claim –

- I will be personally responsible for payment of all accounts incurred by me in relation to medical treatment for injuries sustained in the event that liability is denied or placed in dispute by the Employer or Insurance company
- I take full responsibility for costs of any reports produced by the doctor in the event that liability has been denied

I hereby authorize Mundaring Medical Centre to divulge to my employer and/or employer's insurer, information in relation to my workers compensation / MVA claim or public liability claim. I understand that Mundaring Medical Centre owns the copyright and all legal rights to my medical records whether created or stored at the medical centre.

Name (PRINT) .... Signature .... DOB .../.../...

Date .../.../... Witnessed by ....

Please circle: Workers Compensation / MVA / Public Liability / Neither