BURNIE GP superclinic

Patient Health Information Summary Sheet

Personal Details:

Title_____ Given Names_____ Surname_____ Preferred Name_____

Date of Birth: _____ /_____/_____ Male ☐ Female ☐

What is your ethnicity _____ Spoken Language_____

Are you of Aboriginal or Torres Strait Islander origin? Yes ☐ If yes please specify below No ☐

Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐

Does the patient requires a carer? Yes ☐ No ☐

Does the patient requires a translator? Yes ☐ (Please indicate which language) _____ No ☐

Phone: (H)_____ (M) _____ (W) _____

*Do you consent in receiving SMS reminder messages or email from Burnie GP Superclinic? Yes/No Email*_____

Medicare card _____ No in front of name:_____ Expiry Date_____

Concession card details: Pension card ☐ Health Care card ☐ Veterans Affairs card ☐ Gold / White

Card Number_____ Expiry Date_____

Patient's Home Address:_____

Postal Address (If applicable) _____

Marital Status Single ☐ Married ☐ De facto ☐ Others ☐ (Please Specify)_____

Occupation_____ Country of Birth_____

Emergency Contact Name_____ Relationship to you_____

Emergency Contact Phone (H)_____ (M)_____ (W)_____

Next of Kin Name (write "AS ABOVE" if same as Emergency Contact Name) _____

Social History: Do you smoke? Yes/No Number per day _____ Cease smoking date: _____

Do you drink alcohol? Yes/ No Drinks per day ____ Number of days per week ____Other Drugs? Yes/No _____

Do you have any allergies to drugs or dressings? Yes / No Please specify_____

Are you pregnant? Yes / No / Not applicable Are you planning a pregnancy? Yes / No / Not applicable

Current Medications: Please list _____

Do you use any non- prescription or over the counter medications? Yes / No Please list _____

Past Medical History: Please list the name and dates for any medical conditions_____

Family History: Please list any illnesses that run in your family _____

Privacy Patient Information

To provide high standard of medical care we need to collect personal information from our patients. This information is usually collected from the patient but may be collected from family members and other health provider's with the patient's consent. At times, some of the information needs to be shared with other health care providers or may be legally bound to disclose personal information. All persons accessing your personal health information are bound to confidentiality. Please do not hesitate to discuss any concerns, questions, or complaints about any issues related to the privacy of your personal information with your Doctor.

Signature of Patient or Guardian _____ Date _____ / ____ /____