QUALITY CARE SPECIALISTS

34-36 Mephan St, Maribyrnong. VIC 3032

Tel: (03) 8528 6700 Fax: (03) 9317 5501

Web: www.qcspecialists.com.au

PATIENT DETAILS

Mr/Mrs/Miss/Ms/Mstr _____ Sex: Male / Female

First Name _____ Surname _____

Aboriginal or Torres Strait Islander Yes / No Nationality _____

Occupation _____ Country of Birth _____

Date of Birth _____ Languages spoken _____

Interpreter Services required YES / NO

Married Status Single / Married / Divorced / De facto / Separated / Widowed

Medicare # _____ Reference _____ Expiry _____

Pension / HCC / DVA (White card or Gold card) _____ Expiry _____

Street Number & Name _____

Suburb _____ Postcode _____

Home Phone _____ Mobile _____

Work Phone _____ Email Address _____

EMERGENCY CONTACT

Emergency Contact Person _____ Phone (W/H) _____

Relationship _____ Mobile _____

ALLERGIES

Do you have allergies to any food / medication?

If yes, please give details _____

Do you take any regular medications? (i.e the contraceptive pill and over the counter medications)

If yes, please give details _____

Do you have a history of any significant illness, injury, operations or accidents?

If yes, please give details _____

List any family illness or allergies? (Diabetes, Heart Disease, Cancer etc)

_____

Do you smoke? YES / NO If yes, how many packets per day? _____

Do you drink alcohol? YES / NO If yes, how many glasses on average per day? _____

FEEDBACK

How did you hear about this practice?

- o Yellowpages online
- o Whitepages
- o Google Search Term _____
- o Word of Mouth
- o Street Signage
- o Other, please specify _____

PERSONAL INFORMATION CONSENT

We request your personal details for the purpose of providing comprehensive medical care.

This involves disclosure of this information to other health professionals involved in your treatment and administrative purposes for our medical clinic. For any other purposes, such as research or teaching, you will be informed and have the opportunity to discuss any involvement or objection to these activities.

I consent to the medical clinic using my information for the above purposes.

I agree that all the information I have provided is accurate to the best of my knowledge and accept it is my responsibility to inform the Practice of any change to my details.

If the patient is a child, name of parent / guardian _____

Signature _____ Date _____