We are committed to providing our patients with the best of care. It is essential that your health record is kept up to date and is accurate. Please complete the entire form and be advised that each and every visit you will be asked your name, address and phone number to ensure ongoing accuracy of your health record.

Please provide this page to the receptionist.

Patient Information and Consent Form

Title: *(Please circle)* **Mr Mrs Ms Miss Mstr Dr Prof**	
Surname:	
First Name:	**Middle Name:** *(if applicable)*
Street Address:	
Suburb:	**State:** **Postcode:**
Postal Address: *(if different from street address):*	
Mobile Phone:	**Work Phone:**
Date of Birth: Day: Month: Year:	**Home Phone:**
Are you Aboriginal or Torres Strait Islander? Yes ☐ No ☐	**Ethnicity/Cultural Background:**
Is English your First Language? Yes ☐ No ☐	**If no, do you require an interpreter? Yes ☐ No ☐**
Medicare Card Number:	**Ref #: Exp Date:**
Pension or Health Care Card Number:	**Exp Date:**
Emergency Contact Name: Phone Number:	**Relationship:**
Private Insurance Fund Name: Fund Member Number: **Are you a BUPA or ALLIANZ OSHC Member? Yes ☐ No ☐**	**Exp Date:** **If yes, please provide us your card for photocopying to file**
Email Address:	

I (Print) ________________________________ give my consent to be contacted by OCNL Street Medical Centre regarding my test results and reports.

I consent to being contacted via:

☐ Telephone ☐ Voicemail ☐ SMS ☐ Email ☐ Letter

**** By supplying your email you consent to O'Connell St Medical Centre using it for marketing purposes (mainly newsletter) by O'Connell Street Medical Centre.***

☐ **Opt Out**

Preventative Care and National Reminder Systems

Our practice provides our patients with preventative care reminders and participates in National Recall and Reminder systems (Eg: National PAP Reminder Register, Bowel Screen Australia) as well as in house health promotion and reminders.

How did you hear about us?

☐ Google Search ☐ Friend/Family ☐ Health Engine ☐ OCNL Flyer ☐ Shop a Docket
☐ OCNL Website ☐ Facebook ☐ Hotel Referred Name of Hotel:_____________________________
☐ Walk Past ☐ Gateway portal ☐ Other: ____

It is our practice policy that you are responsible for your own health and, as such, you will need to make an appointment to see your doctor for all test results. Results and consultations will not be provided over the phone in any circumstance. Signing below confirms you understand this statement and have understood and read all other policies notices on this form.

Signature of Patient or Parent/Guardian: ………………………………………………………… Date: ………………………………

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This part is to be given to the doctor for privacy reasons.
Please keep after completion and hand to your treating doctor when the consult commences.

Full Name: .... DOB: ....

Personal Medical History

Do you SMOKE?

☐ No ☐ Ex-Smoker (If a previous smoker, When did you quit? ________________)

☐ Yes Number of Cigarettes Smoked (currently or previously) ________________________/ day

Do you DRINK ALCOHOL?

☐ No

☐ Yes How many days a week do you Drink? ________________ How many Standard drinks per day? ________________

OCCUPATION:

MARITAL STATUS: Single/Married/Divorced/Defacto/Widowed

Do you have any ALLERGIES?

☐ Nil Known

☐ Yes (please specify):____

FAMILY HISTORY:

Does your mother or father have any history of the following:

Diabetes	Hypertension	Heart Disease	Stroke	Colon Cancer	Depression	Breast Cancer
☐Mother ☐Father	☐Mother ☐Father	☐ Mother ☐Father	☐Mother ☐Father	☐Mother ☐Father	☐Mother ☐Father	☐Mother ☐Father

Do any of your immediate or extend family have any significant health concerns? Please list them here (if any):

____

____

☐ I do not know my family history (ie. Adopted)

Are you taking any medications currently including aspirin and over the counter medications?

☐ No

☐ Yes (Please list) ____

____

Please advise your doctor of all medications you are taking, including alternative medications and supplements

Signature of Patient or Parent/Guardian: .... Date: ....

Notes from GP:

CONFIDENTIAL