ABSOLUTE HEALTH & SKIN CLINIC – MEDICAL INFORMATION SHEET

Mr / Mrs / Ms / Miss / Dr / Other **Married/ De Facto/ Single/ Divorced/ Widowed/ Separated**

First Names: _____ **Last Name:** _____

Known as: _____ **DOB:** _____/ _____/ _____ **Gender:** □ Male □ Female □ Intersex

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Do you identify as Aboriginal or Torres Strait Islander origin? □ No □ Yes: Aboriginal / TSI / Both

Ethnicity: Please advise your ethnic background: □ Australian □ NZ □ Sth American □ Nth American □ Asian □ African
□ North/West European □ South/East European □ _____

Medicare Number: __ __ __ __ __ __ __ __ __ __ **Ref No:** ___ (# beside your name) **Expiry:** _____/_____

Centrelink Number: __ __ __ __ __ __ __ __ __ __ **Expiry:** _____/ _____/ _____ **Pension / HCC** (please circle)

DVA Verteran Number: _____ **Expiry:** _____/ _____

Street Address: _____

Suburb: _____ **Postcode:** _____

Postal Address: _____ **Postcode:** _____

Phone Number: (Home) _____ **Work:** _____ **Mobile** _____

Email: _____ **Occupation:** _____

Country of Birth: _____

Next of Kin / Emergency Contact Details:

Name: _____ **Relationship:** _____

Address: _____ **Phone:** _____

Have you any allergies? (including drugs and dressings)

_____

Family History: Please select any that apply

□ Melanoma □ Diabetes □ Heart Attack □ Stroke □ Hypertension

□ Depression □ Migraine □ Asthma □ Cancer – Please specify: _____

Social: Please select one of the following that applies most to you

Smoking: □ Non-Smoker □ Ex-Smoker □ Smoker – Amount ____/ day

Alcohol: □ Non-Drinker □ Daily: ___/ day □ Weekly ____/ day □ Monthly ____/ day

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Measurements:

Height: _____**cm** **Weight:** _____**kg** **Waist:** _____**cm**

Reminder System: Our practice provides our patients with preventative care and early detection reminders, e.g. immunisations, annual health checks including diabetes, skin checks and CST tests.

Do you wish to have any relevant reminders sent to you? □ Yes □ No

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CONSENT FORM

PATIENT NAME: _____

DOB: _____/ _____/ _____

We require your consent to collect personal information about you. Please read this information carefully and sign were indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means that we will use the information you provide in the following ways:

- For administrative purposes in running our practice
- For billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- For disclosure to other involved in your health care, including treating doctors and specialists outside this practice. This may occur through referral to other doctors, or for medical test and in the reports or results returned to us following the referrals.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than those which are set out above my further consent will be obtained.

I consent to the handling of my information by this Practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this Practice of.

I consent to the taking of my photograph for clinical purposes. ☐ **YES** ☐ **NO (PLEASE TICK)**

I understand that this is a confidential medical document. It will be viewed by the doctor or nurse involved in my care and I hereby give permission for it to be scanned electronically into my computerized clinical record.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE** ____ / ____ / ____