HEALTH AT DULWICH – PATIENT INFORMATION SHEET

Surname: _____ **Please Circle: Mr / Mrs / Ms / Miss / Dr**

First Names: _____

Preferred Name: _____

Date of Birth: _____

Street Address: _____

Suburb: _____ **Post Code:** _____

Postal Address: _____

Suburb: _____ **Post Code:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile:** _____

Email Address: _____ **Permission to SMS: YES NO**

Medicare Number: _____ **Reference Number:** _____ **Expiry Date:** _____ / _____

Concession Card Number (HCC, Pension, DVA): _____ **Expiry Date:** _____

Occupation: _____ **Cultural Background:** _____

Please Tick: ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Both Aboriginal & Torres Strait Islander**

☐ **Neither Aboriginal nor Torres Strait Islander** ☐ **Decline to Respond**

Next of Kin: **Name:** _____

Relationship to You: _____

Mobile: _____ **Home Phone:** _____

Emergency Contact: **Name:** _____

(if different to next of kin) **Relationship to You:** _____

Mobile: _____ **Home Phone:** _____

Allergies: _____

Medications: _____

_____

Current Medical Problems: _____

_____

Family History: _____

_____

Please Tick: ☐ **Smoker** ☐ **Non-Smoker** ☐ **Ex-Smoker**

Usual Doctor's Name: _____

I give consent to Health at Dulwich to release relevant information to other medical practitioners that I am referred to.

Please Sign: _____ ***Date:*** _____