Spring Farm Medical Centre

Patient Details		
Title: Mr / Mast / Mrs / Ms /Miss / Mx (please circle)	**Birth Sex:** Male / Female (please circle)	
Family Name:	**Given Name:**	
Date of Birth: / /	**Gender Identity:** Female/Male/Non-Binary/ Gender Diverse/ Transgender/Different Identity (please circle)	
Street Address:		
Suburb:	**Post Code:**	
Mobile Phone:	**Home Phone:**	
Work Phone:	**Occupation:**	
Email:		
Medicare No:	**IRN** (# next to name)	**Expiry:**
Pension OR Health Care Card No: (please circle)		**Expiry:**
Next of Kin/ Emergency Contact: Name: Relationship: Ph:		

Further Details

Ethnicity/cultural background:

☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander
☐ Australian

Other: _____

How did you hear about this Medical Centre?

Medical Information

Do you smoke? ☐ No ☐ Yes ☐ Ex-Smoker

Height: _____
Weight: _____

Alcohol: ☐ No ☐ Yes **Days per week:** _____ **Standard drinks per day:** _____

Family History (please circle):

If other, please specify: _____

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

Do you have any allergies?

☐ Yes: _____ ☐ No

I give consent for my personal health information to be used for administrative purposes to assist in the running of Spring Farm Medical Centre, including SMS appointment reminders and disclosure to others involved in my healthcare, such as Doctors/Specialists within & outside of this Practice. This may occur through referral to other Doctors, for medical tests & in the reports/results returned to my GP following referral.

Signature: _____ **Date:** _____