adelaide health care

We are committed to providing our patients with the best care.
To do this it is essential that your health record is kept up to date and accurate.

Title (please circle)	Dr	Mr	Mrs	Ms	Miss	Mast
Surname						
First Name					**Middle Initial:**	
Date of Birth						
Street Address						
Suburb and Post Code						
Home Phone No.						
Work Phone No.						
Mobile Phone No.						
Your permission is required to protect your privacy - if we need to contact you by phone or SMS, may we leave a message or send an SMS to your mobile? ☐ Yes ☐ No						
Do you give us permission to contact you by email (we DO NOT send junk mail)? ☐ Yes ☐ No						
Email Address						
Medicare Number and *Ref No.* (No. in front of your name)	***No.***		***Ref:***	**Expiry Date**		
DVA Gold or White Card No. (Please circle which)				**Expiry Date**		
Pension/Health Care Card No. (Centrelink or pension card)				**Expiry Date**		
OSHC Number (Allianz overseas insurance)				**Expiry Date**		
Ambulance Cover	☐ Yes ☐ No					
Do you wish to identify yourself as being:	☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Other cultural group (please specify) _____					
Next of Kin	**Name:** **Relationship:** **Mobile or Home No:**					
Emergency Contact Person (if different to Next of Kin)	**Name:** **Mobile:** (Name and Telephone number of the person we can contact in case of an Emergency)					

PLEASE TURN OVER AND CONTINUE

adelaide health care

Please list any family members that also attend this Practice	**Name:** _____ **Relationship:** _____ **Name:** _____ **Relationship:** _____ **Name:** _____ **Relationship:** _____ **Name:** _____ **Relationship:** _____
Employer Name	

REMINDER SYSTEMS

As part of providing high quality comprehensive health care our practice routinely sends reminders via letter or a secure "SMART Recall"SMS reminder for a number of preventative health activities and follow ups.

PATIENT PRIVACY

The personal health information that you provide during your consultation and subsequent treatment will be used for the purposes of providing you with high quality health care. Our policy is to protect your privacy and accordingly the information you provide will only be disclosed to other members of our multi-disciplinary team at Adelaide Health Care. This includes our doctors, practice nurses and clinical pharmacist. It will be disclosed to other organisations where required by law. Your contact details may be disclosed for billing or debt recovery purposes.

A copy of our full Patient Privacy Policy is available on our website or at reception. If you have any concerns about the way we manage your health information, please let us know. In the first instance this can be done by contacting the Practice Manager or your doctor. If you are still dissatisfied, you can contact the Federal Privacy Commissioner at:

Office of the Australian Information Commissioner (OAIC)
GPO Box 5218
SYDNEY NSW 2001

Website: www.oaic.gov.au
Privacy Hotline: 1300 363 922

PAYMENT

You understand that payment of all accounts is your responsibility. You will be charged a fee if you do not attend your appointment without providing a minimum of four hours' notice. All accounts, other than accounts which are bulk billed to Medicare or which are billed to other Third Party payers, are payable in full at the time of treatment. For your convenience we can accept Cash, EFTPOS or Credit Card. You understand that in the event that accounts which are bulk billed to Medicare or which are billed to other Third Party payers are not honoured by such payers then payment of such accounts is your responsibility. You also undertake to pay any debt collection and legal costs that may be incurred by Adelaide Health Care as a result of late payment or non-payment of accounts.

Thank you for providing this information, which will assist in your health care.

Please answer: We would like to know – how did you hear about our practice?					
Friend	Relative	Adel Health Care Website	Online Booking	White Pages	Yellow Pages
Hospital	Chemist	Allied Health	Hotel	Backpackers	Work Nearby
Fridge Magnet	Walk in	Google			
Other (please specify):					

DATE: _____ **SIGNATURE:** _____

All information will be kept confidential

PATIENT HEALTH DETAILS

Please complete and give to your Doctor at your appointment.

Your name please:_____ Occupation: _____

Reminder Systems:

As part of providing high quality comprehensive health care our practice routinely sends SMS or postal reminders for a number of preventative health activities and follow ups.

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds – do you identify as someone from a culturally and/or linguistic diverse background?

☐ Yes - Please elaborate……

To assist with health initiatives - are you Aboriginal or Torres Strait Islander?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ Yes - Aboriginal & Torres Strait Islander ☐ No

Your health history - do you have or have you had a history of?

☐ Operations

_____

☐ Asthma

_____

☐ Diabetes

_____

☐ Heart disease / Stroke / high blood pressure. Circle relevant answer

_____

☐ Mental Health Problems

_____

☐ Other

_____

Current medications (including over the counter medications, vitamins and minerals):

_____

_____

_____

_____

Do you have any allergies or are you sensitive to any drugs or dressings? If so,what reaction have you experienced ?

_____

_____

_____

Immunisations:
Did you receive all the schedule/recommended vaccinations which were offered as a child and in highschool? yes/no
When was the last time you received a vaccination for:

Flu? Date:---------- not sure / never

Pnuemonia? (if you are 65 or over) Date?---------- not sure / never

HPV (Gardasil) Date?---------- not sure / never

Tetanus? Date?----------not sure / never

Whooping Cough (pertussis)---------- not sure / never

Family history - have any members of your family had:

☐ Diabetes

☐ Asthma

☐ Heart Disease/high blood pressure/stroke

☐ Mental illness

☐ Cancer

Social history

Have you ever smoked? ☐ Yes ☐ No
Are you a current smoker? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No

Are you a drug user? ☐ Yes ☐ No Type & frequency _____

When was your last:
Blood pressure check? within last 12 months / 1-2 years ago / not sure

Blood test for cholesterol? within last 12 months / 1-2 years ago / not sure

Weight/BMI check? within last 12 months /1-2 years ago /not sure

Females: When did you last have?
Pap smear: Date: _____ ☐ not sure ☐ never
Breast Check Date: _____ ☐ not sure ☐ never

Males: When did you last have?
Prostate check? within last 12 months /1-2 years ago /3-5 years ago / never