WHITE HILLS
MEDICAL PRACTICE

PATIENT DETAILS

Title:	First Name:	Surname:	
Known As :	DOB:	Gender: M F TG	
Aboriginal/Torres Strait Islander Status:	Non Indigenous Aboriginal Torres Strait Islander Aboriginal & TSI		
Medicare Number:	Reference number:	Expiry date:	
Concession:	Nil Pension Health Care Card Veterans = Gold White		
Number:	Expiry:		
Name of Health Fund:			
Health Fund Number:	Level: Top Intermediate Basic Extras:		
Residential Address:			
Suburb:	Postcode:		
Postal Address:			
Phone Numbers:	Home:	Work:	Mobile:
Email:			
Would you like a SMS confirmation of an appointment?	Yes ☐	No ☐	
Marital Status: Single Married Widowed Divorced Defacto Separated			
Occupation:			
Country of Birth:			
Ethnicity:	Spoken Language:	Preferred Language:	

Next Of Kin (NOK):

Title:	First Name:	Surname:	
Residential Address:			
Suburb:	Postcode:	Relationship:	
Phone Numbers:	Home:	Work:	Mobile:

Different to NOK

Emergency 1:	Title:	First Name:	Surname:
Phone Numbers:	Home:	Mobile:	Relationship:
Accounts to be sent to:			
Pharmacy:	Phone number:		
Pharmacy Address:			
Previous Doctors name and contact details:			

Allergies - Mark Below No Known ☐

Iodine (Betadine) ☐ Adhesives ☐ Lignocaine ☐

Others (Please list)

Do you have any of the following?

	Yes	No		Yes	No
Diabetes 1 / 2	☐	☐	Osteoporosis	☐	☐
Chest Pain / Angina	☐	☐	Osteoarthritis	☐	☐
High Blood Pressure	☐	☐	Gout	☐	☐
Heart / Cardiac Disease	☐	☐	Peripheral Neuropathy	☐	☐
Heart Attack	☐	☐	Back Problems	☐	☐
Stroke/CVA	☐	☐	Mental Health Condition	☐	☐
Blood Borne Disease (HIV)	☐	☐	Visual Impairment	☐	☐
Kidney Disease (Dialysis)	☐	☐	Hearing Impairment	☐	☐
Cancer	☐	☐	Intellectual Disability	☐	☐
Anaemia	☐	☐	Alzheimer's / Dementia	☐	☐
Lung/Respiratory Disease COPD Emphysema	☐	☐	Neurological condition (i.e. MS, MND, Epilepsy	☐	☐
Rheumatoid Arthritis	☐	☐	Skin Abnormalities	☐	☐
Asthma / Breathing difficulties	☐	☐	Liver Disease (Hepatitis)	☐	☐
Foot infection / Ulcer	☐	☐	Physical Disability	☐	☐
Thyroid Condition	☐	☐	Oedema / Swelling legs	☐	☐
Are you Pregnant	☐	☐	Surgery	☐	☐
Pacemaker	☐	☐	Hip Replacement	☐	☐
Heart Bypass	☐	☐	Valve Replacement	☐	☐
Back Surgery	☐	☐	Knee Replacement	☐	☐
Amputation	☐	☐	Foot/Ankle	☐	☐
Smoking	☐	☐	How many per day?		_____
Drink Alcohol	☐	☐	Standard drinks per day?		_____

Do you have any current Injuries/conditions:

If yes are the injuries/conditions

☐ Work Related. Do you have ongoing work cover claim?	Yes ☐	No ☐
☐ Motor Vehicle Accident. Do you have an ongoing TAC claim?	Yes ☐	No ☐
Have you had related Surgery	Yes ☐	No ☐
Female patients: Have you had a PAP Test in the last 2 years	Yes ☐	No ☐

Date of last PAP Test_____

If yes to any of the above please briefly explain

_____

_____

_____

_____

_____

_____

I accept that I am responsible for payment of all debts incurred at White Hills Medical Practice in my name including all family members, is my responsibility.
I also accept that I am responsible for all accounts incurred for Insurance claims from either Medicare, Work cover, TAC or any other Insurance claims that are rejected by the relevant authority or organisation.
By signing this Form I acknowledge that I have read, understand and accept the above statement of conditions.

Signature: _____ Date: _____

Please note that we value your time and appreciate helping you with your health care needs.
Your appointment is important to us and any missed appointments may incur a missed appointment fee.