THE DOCTORS.
Hope Island

PERSONAL INFORMATION FORM

(to be returned to Reception)

Title MR / MRS / MS / Miss / Master / Dr / Other_____(Please Specify)

Pronouns HE/HIM , SHE/HER , THEY/THEM , OTHER _____, PREFER NOT TO SAY.

Surname_____ **First Name**_____

Preferred Name (if different to above) _____

If you have/are an Authorised Representative (i.e Guardian, Parent, Power of Attorney)

Representative Name_____ **Authority type**_____

Date of Birth: ___/____/___ **Birth Sex:** Male / Female **Identify as:** Male / Female / Other_____

Ethnicity _____**Do you identify as an Aboriginal or Torres Strait Islander?** YES / NO

Marital Status: Single / Married / Defacto **Occupation:** _____

Address:_____

Suburb: _____ **Postcode** _____

Home Telephone: _____ **Work Telephone:** _____

Mobile: _____ **Email:** _____

Is English your native language? Y/N | If no, what language is?_____

Do you require the services of an Interpreter to assist you when seeing a Doctor: Y / N

Do you have any of the following cards? (*You must specify please by circling)

Medicare Card / Health Care Card / Pension Concession Card / Commonwealth Seniors Health Card / Dept Vet Aff

Medicare Number _____ IRN: _____ Expiry; _____

Card Number: _____ Expiry: ____/____/____

DVA Number: _____ White / Gold / Lilac / Orange

Next of Kin Contact Name: _____

Contact Number: _____ **Relationship:** _____

Emergency Contact Name: _____

Contact Number: _____ **Relationship:** _____

Details of the most recent other Health Care Practitioner/s you have consulted:

Name of Practitioner: _____

Name of Medical Practice: _____

Telephone Number:_____

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How did you learn about our Medical Practice? (Please check the relevant box)

Facebook ☐	Google Search ☐	Internet ☐	Word of Mouth ☐
Walk by ☐	Signage ☐	Flyer/Ads ☐	Other ☐

_____

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Full Name: _____

Current Medications: _____

Allergies: _____

Do you Smoke? Yes: number per day _____ **/ Ex-Smoker / Non-Smoker** (Please Circle your response)

Do you Drink Alcohol? Yes: Days per week? _____ **Drinks per Day?** _____

Family History for Heath Conditions _____

_____

Pre-Existing Medical Conditions _____

_____

When did you last have an overall health check-up? Date: _____ **/ Unsure / Never**

When did you last have a pap smear? Date: _____ **/ Unsure / Never / Not Applicable**

PLEASE READ THE FOLLOWING TO GIVE CONSENT

- I understand that I can obtain further information about how THE DOCTORS Hope Island handles my personal information (including my health information) from the Privacy Statement available upon request from Reception or as accessible on our website at **www.thedrshopeisland.au**;
- I Consent to THE DOCTORS Hope Island collecting, using and disclosing my personal information (including health information) For the purposes of providing medical services to me;
- I consent to THE DOCTORS Hope Island communicating with the Health Practitioner nominated by me in relation to my medical services;
- I consent to THE DOCTORS Hope Island communicating with me and sending notifications via SMS messages & email to the nominated mobile phone on this form
- I consent to THE DOCTORS Hope Island in the case of Emergency or where urgent contact is required with me and the clinic cannot after reasonable attempts reach me, they may contact my nominated Emergency Contact nominated in this form;
- I understand that if I am under 18 years old or under an impairment, THE DOCTORS Hope Island may disclose my Personal information to my nominated Authorised Representative.
- I understand that I can withdraw or change my consent at any time and agree to contact THE DOCTORS Hope Island to to inform them of such decision;
- I confirm I have read, understood and agree to the Privacy Collection Notice attached to this form.

PATIENT SIGNATURE or AUTHORISED REPRESENTATIVE SIGNATURE _____

Date: / /

Authorised Representative Name & Capacity (for example: parent / guardian) _____

MARKETING PREFERENCE ☐ I wish to be contacted for future promotions, events, newsletters, special offers and other marketing information from THE DOCTORS Hope Island.