Medical Centre

www.dmcmedical.com.au

Patient Details

Title _____ First Name _____ Surname _____

Known as _____ Date of Birth _____/_____/_____

☐ M ☐ F ☐ Other Interpreter Needed? Y ☐ N ☐ Language: _____

Do you wish to be identified as Aboriginal or Torres Strait Islander? Y ☐ N ☐

Address _____ Suburb _____ Post Code _____

As Above ☐ Postal Address _____Suburb _____ Post Code _____

Mobile _____ Home _____ Work _____

Occupation _____ Email _____

Do you identify with any Cultural Background? ☐ Australian ☐ Italian ☐ Greek ☐ None

☐ European ☐ Asian ☐ Other: _____

Emergency Contact

First Name _____ Surname _____

Relationship _____ Phone _____ Are they a patient at DMC? ☐ Y ☐ N

Billing Information

Medicare Number: _____ Ref (№ beside name): _____ Expiry ___ /_____

NX/HCC/Pension Number (if applicable) _____ Expiry ___ /___ / ____

Confidentiality & Privacy

DMC maintains all medical records under strict confidentiality in accordance with all Commonwealth privacy legislation. For more information please refer to the DMC privacy at: www.dmcmedical.com.au/about/the-dmc-privacy-policy/

I have read the DMC privacy notice and accept the terms as specified in it. **Y ☐ N ☐**

Cancellations

If any changes need to be made to your scheduled appointment it is necessary to give a minimum of 24 hours notice otherwise a cancellation fee may be charged.

Contact

I consent to be contacted via sms, phone and/or email for appointment confirmations, reminders, practice updates and health information.

SMS: Y ☐ N ☐ PHONE (non urgent): Y ☐ N ☐ EMAIL: Y ☐ N ☐

I understand and accept the above information

(Signature) _____ Date _____/_____/ _____

*** Please complete page 2 ***

First Name _____ Surname _____ D.O.B. ___/___/_____

Do you have any allergies? ☐ Yes ☐ Nil Known (Please List)

_____

_____

Have you had a Pap smear/CST? ☐ Yes ☐ No When was your last test? _____

When was your last Tetanus vaccination _____

Lifestyle Information

Do you have any of the following?

☐ Cardiovascular disease ☐ Diabetes ☐ Moderate-Severe Asthma

Do you smoke? ☐ Yes ☐ No If Yes, how many per day? _____

Are you an Ex-Smoker ☐ Yes Date ceased smoking? _____

Do you drink alcohol ☐ Yes ☐ No

If yes, how many standard drinks would you drink on an average day? _____

What exercise do you do?

Type _____

Frequency _____

Medication Summary

Do you currently take any medication? ☐ Yes ☐ No

If yes, please list all medications

_____

_____

How did you hear about DMC?

☐ Family/Friends	☐ Work Locally	☐ Yellow Pages
☐ Live Locally	☐ Professional Referral	☐ Brochure
☐ Internet	☐ Drove/Walked Past	☐ Social Media

***** Please either email to help@dmcmedical.com.au before your appointment,***

or hand to reception on arrival **

Office Use Only:

Initial _____

☐ PS ☐ ATSI ☐ Privacy Policy Consent

☐ MD Scanned ☐ EC Entered Date ___/___/____