Blackbutt Doctors Surgery

Patient Information:

Title: Dr/Mr/Mrs/Ms/Miss/Other :_____
First Name:_____
Middle Name:_____
Surname:_____
Preferered Name:_____
Date of birth: __/__/__ Age: ____ Female/Male
Occupation:_____

To assist with health initatives -
Do you identify as Aboriginal or Torres Strait Islander
□ Yes - Aboriginal & Torres Strait Islander
□ Yes- Aboriginal
□ Yes - Torres Strait Islander
□ Australian
□ Other: _____

Contact Details:

Residential Address:
_____
_____
Suburb:_____
Postcode:_____

Postal Address(If different):
_____
_____
Suburb:_____
Postcode:_____

Home Phone:_____
Work Phone:_____
Mobile:_____
Email:_____

Do you consent to SMS & Email contact
□ Yes - Email & SMS
□ Yes - SMS
□ Yes - Email
□ No

How Did you hear about us?
□ Radio □ Friend
□ Television □ Internet
□ Other □ Word of Mouth

Next Of Kin Information

Emergency Contact 1

Name:_____
Relationship:_____
Phone:_____

Emergency Contact 2

Name:_____
Relationship:_____
Phone:_____

Please complete if patient is under the age of 16. If patient has multiple medicare cards OR multiple guardians of care please notify reception and provide all supportng documents/Court Orders.

Head of Family

Name:_____
Relationship:_____
Phone:_____
Date of birth: __/__/__ Exisiting Patient □

Third Party Consent

Do you consent to a 3rd party receiving information or to make enquiries such as taking phone calls, emails, receiving results, collecting reports etc from reception and to make and confirm appointments on your behalf.

3rd Party Consent: Yes/No
3rd Party Name:_____
3rd Party Phone:_____
3rd Party Date of Birth: __/__/__

Medical Information

Medicare:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

( ) no.left of name

Expiry:_____

Do you hold a Pension or Health Care Card (Please circle)
Card No:_____
Card Expiry:_____

DVA: Yes/No
DVA Card number:_____
Gold/White/Other:_____

Private Health: Yes/No
Health Fund Provider:_____
Membership Number:_____

Non Attendance/Cancellation Fee Acknowledgement:

As a patient of Blackbutt Doctors I acknowledge and accept that I am required to pay a **$40 non-attendance/cancellation** fee if I do not give 4 hours notice that I will not be attending my appointment.

Information about our fees:

All healthcare services provided by this practice are covered, in part, by Medicare. Full payment of your account is required on the day of your consultation, you are then able to claim from medicare the rebate.

Workcover Claims:

Workcover claims require an approved claim number for us to make a claim from your insurer. If you do not have an approved claim number you will be required to pay the fee yourself and then claim the funds back from your insurer yourself.

Does someone have P.O.A. (Power of Attorney) or Enduring Guardianship for you? ***Yes/No***

To enable us to communicate or release information could you please supply a copy for our records.

I have read and understand all information provided above regarding fees, reminders, privacy and freedom on information. I am aware that at the conclusion of all consultations there will be a request for full payment of the account. I am also aware that should a debt collection agency be employed to recover any unpaid accounts in relation to consultations that additional collection fees will apply.

Name/Guardian:_____ **Signature:** _____ **Date:**_____

Please circle if you have ever suffered from any of the following conditions?

Heart Attack	Yes/No	Osteoporosis	Yes/No
Asthma	Yes/No	Angina or Coronary Heart Disease	Yes/No
Epilepsy	Yes/No	COPD or chronic bronchitis or emphysema	Yes/No
Heart Failure	Yes/No	Deep Vein Thrombosis (DVT) or Pulmonary Embolus (PE)	Yes/No
Diabetes	Yes/No	Irregular Heart Beat or Atrial Fibrillation (AF)	Yes/No
Dementia	Yes/No	Stroke or Transient Ischaemic Attack (TIA)	Yes/No
Thyroid Problems	Yes/No	Mental Health Problems e.g. Depression	Yes/No
Glaucoma	Yes/No	Peripheral Vascular Disease (PVD or PAD)	Yes/No
Cancer	Yes/No	Kidney Problems	Yes/No
High Blood Pressure	Yes/No	Hepatitis	Yes/No

*Do you have a regular Doctor:*_____ *Phone:*_____

Please list any other serious illnesses OR operations and date they started:

_____

_____

_____

Please list all Medications you are currently taking. Include inhalers, injections, tablets, creams & eye drops

Medication: *Dose:*

_____

_____

_____

_____

_____

Are you allergic to anything that you know of e.g. medicines, metals, elastoplast, latex?

_____

_____

If there are any conditions that run in your family please list below:

Have you ever smoked?	Yes/No	Do you smoke currently?	Yes/No
Do you drink alcohol?	Yes/No	How much do you drink?	Yes/No

Women only:

Are you pregnant now?	Yes/No	If yes baby due date: _____
Have you ever had a pap smear?	Yes/No	Date of most recent pap smear:_____
Have you had a mammogram?	Yes/No	Date of most recent mammogram:_____