Riddell Country Practice

Any information you can provide will assist our doctors to provide optimal care for yourself and your family.

All staff are bound by confidentiality agreements to maintain your privacy

Privacy Agreement & Patient Consent:

I understand that Riddell Country Practice and associated Medical Centres comply with the privacy Act (1988) and as part of their privacy policy they are committed to protecting the privacy of individuals and their personal information. My signature below indicates that I have consented to Riddell Country Practice collecting, using, storing and disposing of my personal information; the release of relevant personal information to other health professionals to allow quality medical care; inclusion in a recall register to be advised of follow up visits, medical updates and health information; inclusion in national/state reminder systems/registers and the release of relevant personal information to any prospective employer, their authorised representative and their insurer in the case of a work related consultation or service.

I understand I may withdraw my consent for Riddell Country Practice to use my personal information at any time (exception when legal obligations must be met.) by written notification.

Signed _____ Witness _____ Date_____

Title Surname: Given Names

DOB: Occupation

Birth sex: Gender identity: Pronouns:

If you prefer to provide this information directly to the doctor please advise the receptionist. LGBT Yes ○

Address Suburb Postcode

Phone Home: Work:: Mobile: consent to SMS reminders - Yes ○ No ○

Email address:

Medicare Number: Reference Number: Expiry Date:

Pension Number: Expiry Date:

Health Care Card Number: Expiry Date:

Veteran Affairs Number

Private Health Fund Name: Membership Number:

Country of Birth:

Aboriginal or Torres Strait Islander Yes ○ No ○ Other Nationality ○

In case of emergencies who should we contact?

Name …… DOB ……

Relationship ……..…… Contact Nos ……

Family History

Are you: Married ○ De facto ○ Single ○ Do you speak a language other than English ? Yes ○ No ○ Interpreter required? Yes ○ No

How many children do you have?

Boys:	Ages	Deceased
Girls	Ages	Deceased
Are your parents living	Mother Age	Father Age

If deceased please state at what age and cause of death

Past Medical History

Are you allergic or sensitive to any medications? If so please list

Have you ever been a patient in a hospital? Yes ○ No ○

If yes When and Why? _____

Are you diabetic? Yes ○ No ○

Do you or have you ever had high Blood Pressure No ○ Yes ○ When?

Have you ever suffered from shortness of breath or chest pain No ○ Yes ○ When?

Do you take regular medication please list below

Females: When did you have your last Cervical Screen ?

Social History				***For doctor/nurse use only***	
Do you smoke?		How many per day/wk		Height	Weight
Have you smoked previously?		When did you give up smoking		Blood Pressure:	Body Mass Index:
Drink Alcohol		How many per day/wk		For Medication Review: ☐	For Complete Health Assessment: ☐
Smoke marijuana		How often per day/wk		For EPC Care Plan: ☐ Asthma Review ☐	Pap Smear Review: ☐

More Patient Information/History/Reason for Consult: