LIFELINE MEDICALS

191 INGLIS STREET
BALLAN 3342
PH; 5370-2436 FAX; 8370-2369

Please take a few moments to read and complete the following two pages,
We need this information to provide the best quality care.
Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

Personal Details

TITLE: _____ FAMILY NAME: _____ GIVEN NAME:_____

MIDDLE NAME: _____ PREFERRED NAME:_____

DATE OF BIRTH (dd/mm/yyyy): _____ GENDER: Male ☐ Female ☐

MARITAL STATUS: Single ☐ Married ☐ Defacto ☐ Separated ☐ Divorced ☐ Widowed ☐

CULTURAL BACKGROUND

Knowing your cultural background can help us provide healthcare that meets your individual needs.

Are you of Aboriginal or Torres Strait Islander Origin?

No ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐

Country of Birth: _____

ADDRESS: _____SUBURB:_____POSTCODE:_____

POSTAL ADDRESS: _____SUBURB:_____POSTCODE:_____

HOME PHONE: _____ WORK PHONE: _____ MOBILE: _____

EMAIL:_____

OCCUPATION: _____

MEDICARE CARD NO.: ☐☐☐☐☐☐☐☐☐☐ REF NO.(PLACE ON CARD): ☐ EXPIRY DATE: ☐☐/☐☐

PENSION CARD TYPE: Pensioner Concession Card ☐ Health Care Card ☐ Commonwealth Seniors Health Card ☐

PENSION/HCC NO.: ☐☐☐☐☐☐☐☐☐☐ EXPIRY DATE: ☐☐/☐☐/☐☐

DVA NO.: ☐☐☐☐☐☐☐☐☐ DVA Card Colour: Gold ☐ White ☐ Lilac ☐ Orange ☐

If your DVA card covers certain conditions, please state condition(s): _____

MEDICAL INSURANCE; _____MEMBERSHIP NO;_____

NEXT OF KIN (NOK) DETAILS (e.g. relation or family member):

Name of NOK:_____ Relationship to you:_____
NOK Address: _____
NOK Contact No: _____ Mobile No: _____

Emergency Contact Name;_____ Relationship to you:_____
Address; _____
Contact No;_____ Mobile No; _____

Medical History

Smoking Status: Non-Smoker ☐ Smoker ☐ Ex-Smoker ☐

Alcohol Status; Yes No if Yes - number of days in a week ☐ Occasional ☐

Do you have known allergies? (E.g. medication, food, bees etc.): Yes ☐ please provide details below No ☐

MEDICATION/PRODUCT	REACTION	SEVERITY

Health status - do you have or have you had any history of

PLEASE CIRCLE -

Diabetes; Yes No

Asthma; Yes No

High Blood Pressure; Yes No Not sure

Heart Disease; Yes No

Others……

Current Medications;

1. 5.
2. 6.
3. 7.
4. 8.

Privacy note –

CONSENT: I give my permission for my personal health information/my child's personal health records to be used for administrative purposes to assist in the running of LIFELINE MEDICAL CENTRE, including disclosure to others involved in my healthcare, such as treating doctors, nurses/allied health professionals in this group practice when consulting with you. Specialists within and outside of this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to my doctor following referrals. For National/State or Territory registers (e.g. Cervical screening-pap smear reminders or familiar cancer registries). I consent to be part of recall and reminder systems, including correspondence and notifications via SMS communication, for legal related disclosure as required by a court of law (e.g. subpoena, court order, suspected child abuse etc.), Quality Assurance activities such as accreditation, for disease notification as requested by law.

I have read & understand all information provided above regarding privacy & freedom of information.		
NAME:	**SIGNATURE:**	**DATE:**

Office use only Information entered; Initials……. Scanned to file ☐ Initials……... Allergies Entered ☐ Initials ……