BITS Medical Centre

Patient Personal Details Registry. Each family member to complete please.

Title: **Full Name:**

Also known as: **Date of Birth:**

Sex at birth: Male Female **Gender Identity:** Male Female Intersex Indeterminate Other

Pronouns: She/Her He/Him They/Them

Indigenous Status: Aboriginal Origin Torres Strait Islander Origin Both Neither

Medicare Number: **Ref No:** **Expiry:**

Veteran's Affairs Card Number: **Expiry:**

Pensioner Concession Card number: **Expiry:**

Health Care Card Number: **Expiry:**

Common Wealth Seniors Health Card Number: **Expiry:**

Address:

City/Suburb: **State:** **Post Code:**

Postal Address (leave blank if the same as above):

City/Suburb: **State:** **Post Code:**

Home Phone: **Fax:** **Work Phone:**

Mobile: **Email Address:**

Marital Status: Single Married Widowed Divorced De facto Separated

Occupation: **Country of Birth:**

Next of Kin: **Relationship:** **Phone Number:**

Emergency Contact: **Relationship:** **Phone Number:**

Do you have any allergies? Yes No

If so, please list allergies:

Describe your reaction:

I consent to the use of my personal health information by BITS Medical Centre and other health providers involved in my medical treatment and care. I also consent to the disclosure of my personal information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment: **Yes No**

This practice sends out follow up reminders when routine investigations are due or when test results require a follow up. I consent to receive follow up reminders and recalls to be sent to the above mobile phone or address: **Yes No**

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Do you smoke?	Yes	No	Ex-smoker	If applicable, quit date?
Do you drink alcohol?	Yes	No		How often?
				How many standard drinks?
Do you have children?	Yes	No		If so, how many?

Have you experienced any of the following conditions? (Please tick and specify year on onset)

Condition	Yes	No	Year	Condition	Yes	No	Year
Arthritis				Heart Disease			
Anaemia				Heart Failure			
Angina				Heart Murmur			
Asthma				Hepatitis A, B or C			
Anxiety "Nerves"				History of Substance Abuse			
Birth Defects				HIV/AIDS			
Low Blood Pressure				Kidney Problems			
High Blood Pressure				Liver Problems			
Blood Disorders				Nervous System Problems			
Broken Bones				Pacemaker			
Cancer				Pneumonia			
Chemotherapy				Post-Traumatic Stress			
Diabetes				Radiation Therapy			
Endocrine Problems				Rheumatic Fever			
Epilepsy				Stroke			

Please give details:

Is there a family history of one of the above mentioned conditions? If yes, specify which condition and family member.

Have you ever undergone surgery? Please specify.

Signature: **Date:**

If not patient, relationship to patient:

PRACTICE USE ONLY: Witnessed by: (staff signature):