ARGYLE MEDICAL CENTRE
5 FENWICK CRESCENT
GOULBURN NSW 2580
TELEPHONE: (02) 4821 1188 Fax: (02) 4821 9111
argylemc@bigpond.net.au

PATIENT DETAILS FORM

Please complete the following information and return to our reception staff

Mr/Mrs/Miss/Ms/Mast/Other: _____ Family Name: _____ Given Name: _____

Middle Name: _____ Preferred Name: _____ Date of Birth_____

Sex: ☐ M ☐ F: ☐ OTHER:_____ Religion: _____ Occupation: _____

Ethnicity:

1. ☐ Australian, non-indigenous **2**. ☐ Aboriginal but not Torres Strait Islander: **3.** ☐ Torres Strait Islander but not Aboriginal: **4.** ☐ Both Aboriginal and Torres Strait Islander. **If you ticked 2, 3 or 4 -** Are you registered for Closing The Gap? – (The Program applies to prescriptions for PBS General Schedule medicines only). ☐ Yes ☐ No If **No** would you like us to register your name for this program? ☐ Yes ☐ No

☐ **5.Other** (Please specify) _____

Country of Birth: _____

Residential Address: _____

Postal Address (if different from above):_____

Phone Numbers: Home: _____ Work: _____ Mobile:_____

Preferred contact number: ☐ Home ☐ Work ☐ Mobile

Email address: _____

Medicare Number: _____ Position on card: _____ Expiry Date: _____

Person listed as number 1 on your Medicare Card: _____

Concession Cards: ☐ Health Care Card ☐ Pension Card ☐ C'Wealth Senior's Card ☐ DVA Card

Card number: _____ Expiry: _____

Private Health Insurance: Fund Name_____ Policy Number_____

Usual Doctor: ☐ Dr. Ivan Wilden-Constantin ☐ Dr. Sawsan Mtelej ☐ Dr. Tim Clancy

Next Of Kin Details

Name: _____ Address: _____

Phone No: _____ Alternate Phone No: _____ Relationship: _____

Emergency Contact Details **Or tick to use Next of Kin details** ☐

Name: _____ Address:_____

Phone No: _____ Alternate Phone No: _____ Relationship: _____

→ → → → *PTO to complete information*

HOW WOULD YOU LIKE THE PRACTICE TO COMMUNICATE WITH YOU?

(a)Would you like to receive test results via Email? ☐ **Yes** ☐ **No** (Please bear in mind that the email address supplied should be private to you and information contained in the email may also be compromised if it is not secure).

(b) Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email or telephone for procedures such as vaccinations, Pap tests and other health reviews

I consent to being contacted with reminders to help me maintain my health ☐ **Yes** ☐ **No**

(c)Do you give permission for information to be given to other health care providers e.g. hospital, specialist doctor, podiatrist, psychologist, pharmacist in the course of your care? This information may be sent via email. ☐ **Yes** ☐ **No**

(d)Do you require the services of a language interpreter? ☐ **Yes** ☐ **No**

(e)Do you require assistance with reading or understanding medical terminology? ☐ **Yes** ☐ **No**

ABOUT YOUR HEALTH

Do you have any of the special needs listed below?

Hearing impairment ☐ Yes ☐ No

Vision impairment ☐ Yes ☐ No

Physical impairment ☐ Yes ☐ No

Other ☐ Yes Please advise: _____

Allergies

☐ Nil known allergies

List allergies or reactions to medications	Describe your reaction

Signed_____ **Dated**_____

Office Use Only											
Entered	Date	Initial	Checked	Date	Initial	Scanned	Date	Initial	Nurse	Date	Initial