Wahroonga Family
MEDICAL PRACTICE

We are committed to providing our patients with the best of care. It is essential that your health record is kept up to date and is accurate. Please complete the entire form and be advised that each and every visit you will be asked you name address, and phone number to ensure ongoing accuracy of your health record.

Patient Details and Consent Form

Title: (please Circle) Mr Mrs Miss Ms Mstr Dr Prof		
Surname:	**First Name:**	
Date of Birth:	**Middle Name:**	
Birth Sex:	**Gender Identity :**	
Home Phone:	**Mobile Phone:**	**Work Phone:**
Street Address:		
Suburb:	**State:**	**Postcode:**
Are You Aboriginal or Torres Strait Islander: (Please Circle) Yes No		
Ethnicity/cultural Background:	**Do you require an interpreter?** Y N Language	
Email :		
Medicare Number:	**Ref no:**	**Expiry Date:**
DVA Number Gold / White:		**Expiry Date:**
Centrelink Pension Number:		**Expiry Date:**
Health Care Card Number:		**Expiry Date:**
Seniors Health Card:		**Expiry Date:**
Next of Kin (The person we can contact if needed)	**Full Name:**	**Phone:** **Relationship :**
Emergency Contact (The person we can contact if Different to your Next of Kin)	**Full name :**	
	Phone:	**Relationship:**

IS THIS CONSULTATION IN RELATION TO A WORK RELATED INJURY (Third party or Workers Compensation)
NO YES

I consent to be contacted by WFMP regarding my test results, reports and preventative health reminders.
It is WFMP Policy that results requiring following up as per your doctors request deemed "clinically significant" our practice staff will contact you to book a follow up appointment for results. **(Please tick if you consent for WFMP to contact you regarding your results and reminders?**

☐ Yes ☐ No

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Personal Medical History

Full Name:	**DOB:**
Do you smoke? (please circle) No Yes (how many cigarettes per day_____ **Occasional/social** (approximately how often) eg-5 cigarettes a month Ex-Smoker (How long ago did you quit**)**	
Do You Drink Alcohol? N Yes	**If yes how often**?
Do you have any ALLERGIES? (please circle)	Nil known Yes (please specify)
FAMILY HISTORY: Does your mother/father have a history of any of the following?	Diabetes
	Hypertension
	Heart Disease
	Stroke
	Cancer
	Depression
	Other – please specify
Are you taking any medications currently: (please list all including over the counter , prescribed medications, and alternative medications**)**	

I understand that fees are payable at the time of consultation. A cancellation fee will apply if I fail to attend an appointment or cancel an appointment without prior notice. Non-payment of fees will result in a surcharge to cover cost of debt recovery. The information we collect on this form is used to ensure we can correctly identify you each time you attend or contact the practice. We ask that you provide a full medical history to your doctor, so that we may properly assess, diagnose, treat and be proactive in your health care needs. **(Please ask reception for a copy of WFMP personal information collection and use policy and the recall and reminder policy should you wish to read further about data collection and our recall systems within our practice.)**

I (Print Name) _____give my consent to be treated for my health related concerns at Wahroonga Family Medical Practice.

Signature of Patient _____ Date_____

PLEASE GVE RECEPTION YOUR SIGNED FORM TO COMPLETE YOUR BOOKING.

WFMP STAFF TO COMPLETE THIS SECTION

Completed by: _____