HAWTHORNE CLINIC

Personal Details

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr Sex: Male ☐ Female ☐

Given Names: _____

Surname: _____ D.O.B: ☐☐/☐☐/☐☐

ETHNICITY (Circle One):

Australian (Non-Indigenous) / Aboriginal / Torres Strait Islander

Other: _____

Address

Street: _____

Suburb: _____ Postcode: ☐☐☐☐

Postal Address (If Different)

Street: _____

Suburb: _____ Postcode: ☐☐☐☐

Contact

Mobile: _____ Home Phone: _____

Would you like FREE SMS reminders of your appointments? ☐ YES ☐ NO

Email: _____

Billing

Medicare Card: ☐☐☐☐ ☐☐☐☐☐ ☐

Reference Number (in front of name): ☐ Expiry: ☐☐ / ☐☐

Pension/Healthcare: _____ Expiry: ☐☐/☐☐/☐☐

(Circle One)

DVA Card: _____ ☐ Gold Card ☐ White Card

Parent/Guardian (Under 18)

Is the Parent/Guardian an Existing Patient? ☐ Yes ☐ No

First Name: _____ D.O.B: ☐☐/☐☐/☐☐

Surname: _____

Medicare Card: ☐☐☐☐ ☐☐☐☐☐ ☐

Reference Number (before name): ☐ Expiry: ☐☐ / ☐☐

Next of Kin / Emergency Contact

Name: _____

Phone: _____

Relationship: _____

PLEASE FILL OUT NEXT PAGE

Medical Information

Current Medications	Allergies and Reactions	Past Surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

Brief Medical History

_____
_____
_____
_____
_____

Immunisations

☐ Tetanus M M / Y Y ☐ Other: M M / Y Y

☐ Influenza M M / Y Y _____

OR

☐ Childhood Vaccines up to Date

Female

Last Cervical Screening: M M / Y Y

Result: ☐ Negative ☐ Other: _____

Would you like to be reminded when next due?

☐ Y ☐ N

Last Mammogram: M M / Y Y

Male (Over 40)

Last Prostate Check: M M / Y Y

Lifestyle

Smoking: ☐ Never ☐ Current _____ per day

☐ Quit M M / Y Y

Alcohol: ☐ Never

☐ Yes: _____ per day

_____ days per week

☐ Past Use:

☐ Nil ☐ Occasional

☐ Moderate ☐ Heavy

Personal History	Mother's History	Father's History
Please tick any of the following that you have had previously:	☐ Alive ☐ Deceased Age at Death: _____	☐ Alive ☐ Deceased Age at Death: _____
☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Heart Disease	☐ Heart Disease	☐ Heart Disease
☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ Stroke	☐ Stroke	☐ Stroke
☐ Cancer	☐ Cancer	☐ Cancer
☐ Asthma	☐ Asthma	☐ Asthma

Patient Contact & Communication

I consent to Hawthorne Clinic contacting me (either by Phone, SMS, Email or letter) for the follow up of results ordered by a Doctor, Health Reminders and Recalls for Preventative Health Services, as well as appointment reminders.

☐ Yes ☐ No

Please be aware that it remains, at all times, the responsibility of the patient to contact the Practice for the results of tests that have been ordered by a Doctor.

Privacy and Consent

I have read the separate laminated document "Health Information Collection and Use – Consent Form," and provide my consent for my health information to be used according to the guidelines outlined in that document.

Patient Signature: _____ Date: D D/M M/Y Y

Parent / Guardian: _____ Date: D D/M M/Y Y

(If Patient Under 16)