Bellbowrie Family Practice

If you identify as an Aboriginal or Torres Strait Islander, are you registered for "Closing the Gap" PBS co-payment relief? **YES/NO**
(If no and you are interested in finding out more information or registering please ask at reception)

☐ Aboriginal
☐ Torres Strait Islander
☐ Neither

Mr/Mrs/Miss/Ms Surname:______________________________

Given Name/s: ______________________________

____

Preferred Name:______________________________

Date of Birth:______/_______/_______

Address:______________________________

Suburb:______________________________

Postcode:__________ State: ____________________

Home Phone:______________________________

Mobile:______________________________

Work Phone:______________________________

Email:______________________________

Occupation:______________________________

Emergency Contact:______________________________

Relationship:______________________________

Telephone:______________________________

Do you give permission for us to contact the above person in the event that we cannot reach you? **YES/NO**

Billing Information:

☐ Medicare card
☐ DVA Card

Card Number:______________________________

Reference Number:_______________Expiry:_____/______/______

☐ Pension Card
☐ Health Care Card

Card Number:______________________________

Reference Number:_______________Expiry:_____/______/______

Do you require your records to be transferred from your previous medical practice? **YES/NO**

Name of Medical Centre:______________________________

Telephone:______________________________

I hereby consent to being a patient at the Practice and I confirm that I agree to observe all the Practice Policies and Procedures

______________________________ ____________________

Signature: (if over 16 or Parent/Guardian) Date:

Medical History:

Have you had any of the following appointments? If yes please provide the date.

Chronic Disease Management Plan _____/_____/_____

Health Assessment 45-49/75+ _____/_____/_____

Mental Health Care Plan _____/_____/_____

Please list any allergies in particular to medications. If you do not have any allergies write "Nil"

Allergies:	**Reactions:**