AUBURN ROAD MEDICAL CENTRE
Healthcare You Can Trust

426 Auburn Road, Hawthorn 3122
P 03 98196616 F 03 98199772
E admin@auburnroadmedical.com.au
W auburnroadmedical.com.au

PERSONAL DETAILS

Title: Mr ◉ Mrs ○ Ms ○ Miss ○ Mast ○ Dr ○

Surname: _____First Name: _____

D.O.B. ____/____/_____ Mobile: _____

Address: _____

Suburb: _____ Post Code: _____

Email: _____

Occupation: _____

Country of Birth: _____

Are you of Aboriginal ☐ Torres Strait Island descent ☐

Medicare/DVA Number: _____

Reference Number (in front of name): _____

Expiry Date: _____/_____

Healthcare Card ☐ Pension Card ☐

_____ exp: ____/_____

TAC/Work cover (circle) Claim no: _____

Private Health Insurance: ☐

If YES, name of fund: _____

Membership Number: _____

MEDICAL HISTORY:

Do you or member of your family have or have had any of the following:

	Asthma	Diabetes	Hypertension
You	☐	☐	☐
Mother	☐	☐	☐
Father	☐	☐	☐

	Cancer	Heart Disease	Depression
You	☐	☐	☐
Mother	☐	☐	☐
Father	☐	☐	☐

How did you hear about us? (please circle)

Word of Mouth ☐ Google Search ☐ Signage ☐

Employer ☐ HealthEngine ☐ Brochure/Flyer ☐

Other (please specify): _____

ALLERGIES: Are you allergic or sensitive to any medications:

YES ○ NO ◉ If YES: _____

Women Only: When was your last Pap smear: _____

Do you take regular medication: NO ◉ YES ○ Please list:

_____

_____

Height: _____(cm) Weight _____(kg)

SOCIAL HISTORY

Do you smoke: YES ○ NO ◉ If YES, how many per day? _____

If you previously smoked, when did you quit? _____

Do you drink alcohol: YES ○ NO ◉

If YES, how many days per week? _____

Standard drink per day _____

EMERGENCY CONTACT: _____

Relationship: _____ Tel: _____

Next of Kin (if different from above):

_____

Relationship: _____ Tel: _____

CANCELLATION POLICY

Auburn Road Medical Center require at least 12 hours notice to cancel or change an appointment. Failure to provide this notice may result in a cancellation fee being charged.

PRIVACY & CONSENT

Auburn Road Medical Center complies with the Privacy ACT (1988) and is committed to protecting the privacy of individuals and their personal information. I have read and understood the above and provide my consent to Auburn Road Medical Center for the collection, usage, storage and disposing of my personal information; the release of relevant personal information to other health professionals for medical care; the inclusion in the practice' s recall and reminder systems, medical updates and information newsletter. I understand that I may withdraw my consent to Auburn Road Medical Center to use and disclose my personal information at any time (except when legal obligations must be met). I acknowledge that the information given on this form is true and accurate to the best of my knowledge.

Signature: _____

Date: _____