Receptionist: Date: Scanned:

North Coast Medical Centre BYRON INTEGRATIVE HEALTH

This information you provide to us is confidential and assists us to provide high quality medical care. It is used to correctly identify you within the practice & in our dealings with Medicare. PLEASE COMPLETE ALL DETAILS - WRITE CLEARLY IN BLOCK CAPITALS

I consent to the practioners at NCMC sharing my clinical information with other practioners at NCMC **YES or NO**

I consent to NCMC sending me SMS: **YES or NO**

FIRST NAME ______________________

SURNAME ______________________

KNOWN AS ______________________ **FEMALE MALE** (please circle)

Date of Birth ___ / ___ / ______

ETHNICITY: ______________________

ADDRESS: ______________________

TOWN/SUBURB: ______________________ **POST CODE:** __________

Aboriginal ☐ **Torres Strait Islander** ☐ **Neither** ☐

MEDICARE NO: ______________________ Ref No: ☐ Valid To: ___ / ___

Pension Card: ______________________ Exp: ___ / ___ / ___

Health Care Card: ______________________ Exp: ___ / ___ / ___

Veterans Affairs: ______________________ Exp: ___ / ___ / ___

MOBILE: ______________________

HOME: ______________________

WORK: ______________________

EMAIL: ______________________

COUNTRY OF BIRTH: ______________________ **OCCUPATION:** ______________________

EMERGENCY CONTACT:

Name: ______________________

Phone: ______________________ Relationship: ______________________

NEXT OF KIN: SAME AS EMERGENCY CONTACT ☐

Name: ______________________

Phone: ______________________ Relationship: ______________________

Patient Signature: ______________________ Date: ______________________

Name ______________________________

Allergies

Do you have any allergies or are you sensitive to drugs or dressings? (Please circle)

NO	**YES** (please specify)

Medical Conditions (Past and present) (e.g. cancer, heart disease, diabetes, asthma, melanoma etc.)

Operations (Please include the year)

Medications (Current medications including over the counter medications & supplements)

Medication	Strength	How many per day

Family Medical History (e.g. cancer, heart disease, diabetes, asthma, melanoma etc.)

Social History

Alcohol **Yes / No** If yes days per week :	Drinks per day :

Smoker **Yes / Never / Ex smoker** (year stopped:)
If you answered yes – how many cigarettes per day do you currently smoke:

Marital Status:	Children:
Occupation:	
Elite Athlete **Yes / No**	

Vaccinations

Tetanus	**Yes / No**	Year:
Influenza	**Yes / No**	Year:
Pneumococcal	**Yes / No**	Year: