Patient Personal Details Registry. Each family member to complete please.

Title: **Full Name:**
Also known as: **Date of Birth:**
Gender: Male Female Intersex/Other Transgender
Indigenous status: Aboriginal origin Torres Strait Islander origin Both Neither

Medicare number: **Expiry:** **Ref no:**
Veteran's Affairs Card Number: **Expiry:**
Pension Card Number: **Expiry:**
Health Care Card Number: **Expiry:**

Do you have any of the following?
Government Seniors Card? Yes No
Private Health Insurance? Yes No **Name of Insurance:**

Address:
City/Suburb: **State:** **Post Code:**
Postal Address (leave blank if same as above):
City/Suburb: **State:** **Post Code:**
Home Phone: **Fax:** **Work Phone:**
Mobile: **Email Address:**
Marital Status: Single Married Widowed Divorced De facto Separated
Occupation: **Country of Birth:**

Next of Kin: **Relationship:** **Contact Phone Number:**
Emergency Contact: **Relationship:** **Contact Phone Number:**

Please list any allergies:

Describe your reaction:

I consent to the use of my personal health information by BITS Medical Centre and other health providers involved in my medical treatment and care. I also consent to the disclosure of my personal information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment: **Yes** **No**

As part of the preventative health service offered by this practice we send out follow up reminders when routine investigations are due.
I consent to receive follow up reminders and recalls to be sent to the above mobile phone or address: **Yes** **No**

BITS Medical Centre

Do you smoke? Yes No Ex-smoker **Do you drink alcohol?** Yes No

Do you have children? Yes No

Have you experienced any of the following conditions? (Please tick and specify year of onset)

Condition	Yes	No	Year	Condition	Yes	No	Year
Arthritis				Heart Disease			
Anaemia				Heart Failure			
Angina				Heart Murmur			
Asthma				Hepatitis A, B or C			
Anxiety "Nerves"				History of Substance Abuse			
Birth Defects				HIV/AIDS			
Low Blood Pressure				Kidney Problems			
High Blood Pressure				Liver Problems			
Blood Disorders				Nervous Problems			
Broken Bones				Pacemaker			
Cancer				Pneumonia			
Chemotherapy				Post Traumatic Stress			
Diabetes				Radiation Therapy			
Endocrine Problems				Rheumatic Fever			
Epilepsy				Stroke			

Please give details:

Is there a family history of one of the above-mentioned conditions? If yes, specify which condition and family member.

Have you ever undergone surgery? Please specify.

Signature: **Date:**

If not patient, relationship to patient:

PRACTICE USE ONLY: Witnessed by: (staff signature)