Fletcher Clinic

Information provided on this form is treated as strictly confidential and will not be provided to any person or entity without your permission. Our practice brochure and privacy policy is available in the waiting room and reception desk.

Patient Details

Title ☐ Mrs ☐ Ms ☐ Miss ☐ Mr ☐ Master ☐ Other

Medicare # _____ Number next to name

Surname _____

Expiry Date _____

First Name _____

Pension / HCC # _____

Date of Birth _____

Expiry Date _____

Sex ☐ Male ☐ Female

DVA Number & Colour _____

Ethnicity _____
(Country of birth if outside Australia)

Marital Status ☐ Married ☐ Separated ☐ De Facto ☐ Widowed ☐ Single

Are you Aboriginal? ☐ Yes ☐ No

Occupation _____

Are you Torres Strrait Islander? ☐ Yes ☐ No

Emergency Contact Details

Address _____

Name _____

Suburb _____

Contact No _____

Postcode _____

Relationship to you _____

Home Ph # _____

(Country of birth if outside Australia)

Mobile # _____

Do you have a Regular GP? ☐ Yes ☐ No

Allergies _____

Alcohol Intake ☐ Yes How many drinks per week? _____ ☐ No

Smoker ☐ Yes How many a day? _____

☐ Non Smoker ☐ Ex Smoker Year you gave up? _____

Family History Is there any family history of major illnesses including: Diabetes, hypertension, breast cancer, bowel cancer, prostate cancer? If so please give details including which family member is affected.

_____

_____

Please turn over

Fletcher Clinic

Please read the information in this form carefully. You are under no obligation to provide consent to the use of your personal information. In the event that you do not consent, we will respect your wishes and will not use the information for any purpose.

Patient Details

Please circle your answer and sign below:

The doctors at the practice make every effort to provide expert medical care which may include referrals to specialists and allied health care providers outside this practice.

As part of my care, I will be responsible for my attendance at every consultation and if I am unable to attend, I will notify staff and/or doctors at the practice. If I do not attend or give less than two hours notice, I am aware that there is a three chance system. On the fourth instance I may receive an invoice as a non-attendance fee.

Initial: _____

I Do / I Do Not take the responsibility to contact the practice and follow up results. I also acknowledge that I may receive an SMS or phone call regarding a follow up appointment.

Initial: _____

I Do / I Do Not acknowledge & consent to Fletcher Clinic contacting me by phone or SMS for SMS appointment reminders, clinical reminders, results follow up and health alert messages.

Initial: _____

My personal and medical information may be used for the purpose indicated below:

To assist other medical practitioners or institutions who may treat me in the future (e.g. specialists). This may include a requirement to forward relevant information, for example, previous test results.

Yes / No

To inform my next of kin or other nominated person, regarding an emergency, or to obtain consent for treatment when I am unable to provide such consent.

Yes / No

To assist us in the requirements for accreditation and audits of our facility by accreditation authorities engaged to assess the surgery's processes and activities.

Yes / No

I have read this form; I understand it and I give my consent:

_____ _____

Name (print) **Signature**

_____

Date

Relationship to patient if another person signs _____

OR I DO NOT GIVE MY CONSENT _____

NAME / SIGNATURE & DATE

Your consent will be stored in your medical record. Thank you for your assistance.