JOHN PARRY MEDICAL CENTRE

– *please update your information and sign at the bottom of the page.*

SURNAME: ____

FIRST NAME: ________________________MIDDLE NAME:_____________________

KNOWN AS:

Residential Address ____

Town_____________________________________ Postcode______________

Postal Address ____

Town______________________________________ Postcode______________

If the same please put AS ABOVE.

State: ________________ Country: ____________________________________

☐ *This is a temporary address.*

Essential information

DOB: *dd/mm/yy* _______________

Born as: M □ F □

Home/Work phone:___________________________

Mobile: ______________________

Email:_________________________

Optional Information

Identifies as_____________________

Preferred pronoun:______________

Medicare nbr	Ref
Expiry date	
Private Health fund	
Membership nbr	
Concession Card nbr	
Expiry date	

JOHN PARRY MEDICAL CENTRE

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- ☐ Aboriginal or TSI origin
- ☐ Neither
- ☐ Registered for CTG

Country of Birth: ___________________________________

Primary Language: ___________________________________

Occupation: _______________________________________

Religion: ____

Ethnicity: ____

Marital Status: ____________________________________

EMERGENCY CONTACT

Relationship	Name	Phone
Next of Kin		

Are you the Account Holder?

- ☐ Yes
- ☐ No – please enter details below.

Name of account holder:	DOB:
Phone:	Email:

I____ *confirm the above information is correct.*

*Signed*____ *Date:*

JOHN PARRY MEDICAL CENTRE

– *please update your information and sign at the bottom of the page.*

MEDICAL INFORMATION QUESTIONS

<table>
<tr><td colspan="3">Usual doctor:</td><td></td></tr>
<tr><td>Do you have any of the following health issues?</td><td>Yes</td><td>No</td><td>Details</td></tr>
<tr><td>Diabetes</td><td></td><td></td><td></td></tr>
<tr><td>Allergies</td><td></td><td></td><td></td></tr>
<tr><td>High blood pressure</td><td></td><td></td><td></td></tr>
<tr><td>Stroke/heart attack/angina</td><td></td><td></td><td></td></tr>
<tr><td>Rheumatic fever or heart murmur</td><td></td><td></td><td></td></tr>
<tr><td>Asthma or other breathing problems</td><td></td><td></td><td></td></tr>
<tr><td>Epilepsy</td><td></td><td></td><td></td></tr>
<tr><td>Indigestion/reflux</td><td></td><td></td><td></td></tr>
<tr><td>Hepatitis/HIV</td><td></td><td></td><td></td></tr>
<tr><td>Do you smoke?</td><td></td><td></td><td></td></tr>
<tr><td>Do you drink alcohol?</td><td></td><td></td><td></td></tr>
<tr><td>If so, how much.</td><td></td><td></td><td></td></tr>
<tr><td>Do you know your height?</td><td></td><td></td><td></td></tr>
<tr><td>Do you know your weight?</td><td></td><td></td><td></td></tr>
<tr><td>Any previous serious illnesses?</td><td></td><td></td><td></td></tr>
<tr><td>Any recent operations?</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="4">Please list all medications you are currently taking:

Do you have:
- Health care plan with another surgery___________________
- Mental health care plan with another surgery_______________

Doctor or nurse to complete:
- Advanced Health Directive______________________________
- Enduring Power of Attorney_____________________________</td></tr>
</table>

JOHN PARRY MEDICAL CENTRE

Dr. P BEATON
Dr. A KERRIGAN
Dr. M JOB
Dr. R MARQUES
Dr. N EZEORAKWE

PO Box 189
Narrogin, W.A. 6312
Telephone (08) 9881 1100
Fax (08) 9881 4301
Email reception@jpmedical.com.au

Phone/Video Consultation Consent Form

Name:
DOB: **00/00/00**

I **DOB: 00/00/00** give my consent to phone/ video consultation with staff from **John Parry Medical Centre.**

Sign:____________________________ **Date:**____________________

Privacy Note: Your personal information is protected by law, including the Privacy Act 1988, and is collected by the Australian Government Department of Services for the assignment and administration of payments and services. This information may be used by the department, or given to other parties where you agree to that, or where it is required or authorised by law (including the purpose of researh or conducting investigations). You can get more information about the way in the department will will manage your personal information including our privacy policy.

Privacy Consent Form

Your **Personal Health Information** may need to be disclosed for the following reasons:

- Communicating relevant information with other treating doctors, specialists or allied health professionals.
- Follow up reminder / recall notices and state reminder systems (eg. cervical screening - pap smears reminders or familiar cancer registries).
- State registers (eg. Immunisation data)
- Accounting / Medicare / Health Insurance procedures.
- Quality Assurance activities such as accreditation.
- For disease notification as required by law (e.g. infectious diseases).
- For use by any of our doctors/nurses/allied health professionals when consulting with you.
- For legal related disclosure as required by a court of law (E.g. subpoena, court order, suspected child abuse).
- Electronic Communications Policy and associated risks
- For research purposes (de-identified, meaning you are not able to be identified from the information given).

This Practice is committed to maintaining the confidentiality of your Personal Health Information. It is the policy of this practice to maintain the security of Personal health Information at all times and to ensure that it is only available to authorised members of staff and to comply with the Privacy Act and Electronic Communications Policy.

Please ask a Staff member if you wish to view our full Privacy Policy and/or Electronic communications Policy

I have been made aware by John Parry Medical Centre of their Privacy Policy, in accordance with freedom of information act 1992. By signing this form I understand & consent to my personal information & medical records being collected, used and disclosed in accordance with, and in no other manner contrary to this document.

Signed: ______________________________ Date:

DOB: