JOHN PARRY MEDICAL CENTRE – *update 29/10/2026*

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

Essential Information

TITLE: _____ **SURNAME:** _____

GIVEN NAME:_____ **MIDDLE NAME:** _____

PREFERRED NAME: _____ **DOB: dd/mm/yyyy** _____

Birth Sex: M ☐ **F** ☐ **Other** ☐

Optional Information

Gender Identity: _____ **Preferred Pronoun:** _____

Essential Information

Ethnicity: ☐ Australian ☐ Aboriginal, ☐ TSI **If Other:** _____

Country of Birth: ☐ Australia **If Other:** _____

Perf. Language: ☐ English **If Other:** _____

Patient's Occupation _____

Usual/ Preferred Chemist: _____

Essential Information

Residential Address: _____

Town/City: _____ **Postcode:** _____

Postal Address: _____

Town/City: _____ **Postcode:** _____

If the same please put AS ABOVE.

Mobile Phone: _____ **Work Phone:** _____

Home Phone: _____ **Email:** _____

Medicare Number	Ref ____	
Expiry date		
Concession Card		Expiry date:
Concession Card Type	☐ Pension Concession Card ☐ Commonwealth Seniors Health Card ☐ Health Card	
Private Health fund		
Membership Number		Expiry date:

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DVA Number	
DVA Disability	
DVA Card colour	
Optional Information Religion: _____	

EMERGENCY CONTACT

	Relationship	Name	Surname	Phone
Head of Family				
Next of Kin				
Emergency Contact				

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:* _____

Complaints: If you have a complaint and feel unable to resolve your concern with us, you may contact: Health and Disability Services Complaints Office. Our receptionist can give you a form to complete or you can contact them on 1800 813 583 or email mail@hadsco.wa.gov.au.

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MEDICAL INFORMATION QUESTIONS

Usual doctor:			
Do you have any of the following health issues?	NO	YES	Details
Diabetes			
Allergies			**(What Else Can You Tell Me About This?)**
Have you had the HPV vaccine?			
High blood pressure			
Stroke/heart attack/angina			
Rheumatic fever or heart murmur			
Asthma or other breathing problems			
Epilepsy			
Indigestion/reflux			
Hepatitis/HIV			
Do you smoke?			
Do you drink alcohol?			
If so, how much.			
Do you know your height?			
Do you know your weight?			
Any previous serious illnesses?			
Any recent operations?			
Other			

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_____

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JOHN PARRY MEDICAL CENTRE

Dr. P BEATON
Dr. N EZEORAKWE
Dr. Y MOHAMED
Dr. U REDDY
Dr. V CHANDRASENA
Dr. N UZOH

57 Williams Road
PO Box 189
Narrogin W.A. 6312
Telephone: (08) 9881 1100
Fax: (08) 9881 4301
Email: Reception@jpmedical.com.au

PRIVACY CONSENT FORM

Your and your child's **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 (e.g. cervical screening - pap smears reminders or familiar cancer registries).

· State registers (e.g. 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.

Name:_____Date of Birth:_____

On behalf of:_____Date of Birth:_____

Signed: _____Date:_____

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ELECTRONIC COMMUNICATION CONSENT FORM

I _____ give my consent to electronic communication with staff from **John Parry Medical Centre**.

☐ Phone/Video Appointments

☐ SMS Appointment Reminders

☐ Clinical Reminders

☐ Clinical Communication (Results & Clinical Messages)

☐ Health Awareness (Leaflets & Database Search)

☐ eScripts

Name:_____Date of Birth:_____

On behalf of:_____Date of Birth:_____

Signed: _____Date:_____

Privacy Note: Your personal information is protected by law, including the Privacy Act 1988, and is collected by the Australian Government Department of Service 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 research or conducting investigations). You can get more information about the way in which the department will manage your personal information including our privacy policy.