Spring Farm Medical Centre

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. Could you please assist us by completing the following?

Patient Details		
Title: Mr / Mrs / Ms / Miss	Date of Birth: / /	
Family Name:	Given Name:	
Street Address:		
Suburb:	Post Code:	
Mobile Phone:	Home Phone:	
Work Phone:	Occupation:	
Email:		
Medicare No:	IRN:	Expiry:
Pension/HCC No:		Expiry:
Health Insurance Fund:		
Health Insurance No:		Expiry:
Next of Kin/ Emergency Contact Name: Relationship: Number:		

Further Details
To assist us with health initiatives, are you Aboriginal or Torres Strait Islander? ☐ Yes - Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Both ☐ No If no, do you identity yourself with a particular ethnicity? _____
Do you wish to have any relevant health reminders sent to you? ☐ Yes ☐ No
Would you like to be registered for eHealth? ☐ Yes ☐ No
How did you hear about this Medical Centre? Please indicate:

Medical Information	
Do you smoke? ☐ Yes ☐ No	Height:_____ Weight:_____
Alcohol: ☐ No ☐ Yes Days per week: _____ Standard drinks per day: _____	
Family History (please circle): Mother: Diabetes Hypertension Heart Disease Stroke Breast Cancer Depression Father: Diabetes Hypertension Heart Disease Stroke Colon Cancer Depression	
Do you have any allergies? ☐ Yes: _____ ☐ No	

Signature: _____ Date: _____