5/30 Victor Harbor Road, Mount Compass 5210
PO Box 352 Mount Compass 5210, SA
Phone: 8556 8365
Fax: 8556 8096
Email: reception@mtcompassmedical.com

Patient Information Form

First Name/s_____ **Middle Name** _____ **Surname** _____

Preferred Name _____ **Title**: _____ **Marital Status**: _____ **DOB** ____/____ /____

Sex at Birth: Female / Male **Gender Identity**: Male / Female / Prefer not to say / Other: _____

Preferred Pronouns (please circle): She/Her Him/His They/Them Prefer not to say Other: _____

Home Address: _____ Suburb: _____ P/C: _____

Postal Address: (if different)_____ Suburb: _____ P/C: _____

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

Email_____@ _____ **Occupation**: _____

Do you consider yourself to be: Aboriginal: _____**Torres Strait Islander:** _____

Do you identify with any cultural or religious beliefs that may affect your acceptance of some medical treatments?

(No) (Yes) : (please indicate)_____

Country of Birth: _____ **Year of Arrival**: _____ **Ethnicity**: _____

Main Language Spoken: _____ **Interpreter/translator required?** _____

Medicare Card Number: __ __ __ __ __ __ __ __ __ __ Reference Number: ____ Exp: _____

Veteran Affairs DVA Card: Gold / White **Card No**:_____ _____ Exp:_____

HCC / Pension Card No: _____ Exp: _____

Private Health Insurance (please circle) Yes / No

Next of Kin
Name_____Relationship_____Phone:_____

Emergency Contact - Same as Above? (Yes) (No, please list below)

Name_____Relationship_____Phone:_____

Consultation Fees

Mt Compass Medical Centre is a private clinic & Bulk Billing is not routine.

- Children under 16 will be Bulk Billed
- Pension & Concession Card Holders will be Bulked Billed
- Private Patient please be advised the FULL payment is required at the time of the consultation
- Fees apply for non-attended appointments or cancellations less than 2 hours prior notice

Patient Signature: _____ Date: _____

MOUNT COMPASS MEDICAL CENTRE

Shop 5/30 Main Rd, PO Box 352 Mount Compass 5210, SA
Phone: 8556 8365 Fax: 8556 8096

Privacy Consent Form

This practice is bound by the *Federal Privacy Act 1998* and National Privacy Principles, and also complies with the *South Australian Health Records Act 2001*. To enable ongoing care and total improvement within this practice, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record **your consent** or restrictions to this consent.
This information includes medical details, family information, name, address, employment and other demographic data, past medical and social history, current health issues and future medical care, Medicare number, accounts details and any health information such as a medical or personal opinion about a person's health, disability or health status.

Your personal health information will only be used for the purpose for which it is being collected, or as otherwise permitted by law and we respect your right to determine how your personal health information is used and disclosed.

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall notices for treatment and preventive healthcare.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of the heath condition, including the communication of information to, practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professional trained non-treating GP's and other professionally trained persons e.g. General Practice Managers.
- For legal related disclosure as required by a court of law
- For the purpose of research only where de-identified information is used.
- For disease notification as required by law
- To allow medical students and staff to participate in medical training/teaching using only de-identified information.
- For the use when seeking treatment by other doctors in the practice.
- For health information communication purposes, between myself and the practice via email or phone

I, _____ give my permission for the personal health Information to be collected, used and disclosed as described above. I understand that only my relevant personal health information will be provided for the above-described purposes and that I can freely withdraw, alter or restrict my consent at any time by notification in writing. I also understand that the practice may communicate with me regarding my health information via phone, email or mail

Patient Name: _____

Signature: _____

If not Patient signing, name: _____Relationship_____

PRACTICE ONLY: Witnessed by: (staff signature):_____

First and Last Name: _____

Medical History & Information Page 1 of 2

Allergies and Adverse Reactions

Do You Have Any Known Allergies?	**YES**	**NO**
Please list any known allergies and adverse reaction		
Allergen (example: peanuts)	**Reaction (example: anaphylaxis)**	

Smoking (please circle your answer)

Do You Smoke?	YES	NO	**Are You an Ex-Smoker?**	YES	NO
How Many Do You Smoke Daily?			**What Year Did You Quit?**		

Alcohol Consumption (please circle your answer)

How often do you have an alcoholic drink?				
Never	Monthly or less	2-3 times a week	2-4 times a month	4+ times a week
How many standard drinks do you have on a typical day?				
1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 6 or more drinks on one occasion?				
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

First and Last Name: _____

Medical History & Information Page 2 of 2

Condition	Yes	Year	Condition	Yes	Year
Low Blood Pressure			Abdominal Aortic Aneurysm		
High Blood Pressure			Vascular/ Circulation Problems		
Pacemaker			Asthma		
Heart Attack			COVID infection		
Irregular Heart Beat (AF)			COPD (Emphysema/ Bronchitis)		
Rheumatic Fever			Pneumonia		
Angina			Anxiety		
Heart Failure			Depression		
Heart Stent/ Bypass			PTSD		
Heart Murmur			Panic Attacks		
Cancer **(Please Specify)**			Diabetes **(Please Specify)**		
Kidney Problems			Thyroid Problems		
Liver Problems			Arthritis		
Blood Disorders			Other Joint Conditions		
Chemotherapy			Mini Stroke TIA		
Radiotherapy			Stroke CVA		
GORD/ Reflux			Epilepsy		
Crohn's /Ulcerative Colitis			Multiple Sclerosis (MS)		
Colonic polyps			Diverticular Disease		
IBS			Neurodivergence (ADHD, Autism, etc)		

Screening Type	Have you ever been screened?		Year	Result
PSA (prostate cancer)	YES	NO		
FOBT (bowel caner)	YES	NO		
CST (cervical cancer)	YES	NO		
Skin Cancer Check	YES	NO		