INTEGRATED ENDOCRINOLOGY AND METABOLISM

Date : _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Middle Name: _____ Birth Date: _____

Sex: ◯ Male ◯ Female ◯ Intersex Gender: ◯ Male ◯ Female ◯ NB Other _____

Pronouns: ◯ He/his ◯ She/her ◯ They/them

Address: _____

City: _____ State: _____ Post Code _____

Postal address ◯ As above _____

Email: _____ Mobile: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Aboriginal or TSI origin: ◯ Neither ◯ Aboriginal ◯ TSI ◯ Both ◯ Decline to answer

Referring doctor: _____ Referring doctors practice: _____

Regular GP ◯ As above _____ Regular GP practice: _____

MEDICARE AND INSURANCE INFORMATION

Medicare Number: _____ Ref No. _____ Exp. date _____

Health Insurance Fund: _____ Membership number: _____

Level of Cover: ◯ Hospital ◯ Extras ◯ Not Sure

Pension or Health care card number _____ Exp. date _____

DVA number _____ ◯ Gold ◯ White Exp. date _____

I have read and understand the information contained in Integrated Endocrinology's Privacy Policy, including:

- the types of personal information collected by the Practice, the reasons why it is necessary to collect it and the circumstances in which my personal information may be used or disclosed
- that I may request access to my personal information, which may be granted in accordance with the Practice's Access to Personal Information Policy. I will be provided with a written reason if access is denied
- that I am not obliged to provide the Practice with my personal information, but withholding information may limit the Practice's ability to provide me with full service.
- that I have the right to lodge a complaint about the handling of my personal information if I am dissatisfied, which will be dealt with in accordance with the Practice's complaint handling procedure.
- I acknowledge that my personal information may have to be disclosed to, or collected for, Government and Health Fund statistics or to other treating health professionals so that my health care is not compromised. It will, however, be disclosed to other organisations where required by law or if necessary for debt collection purposes.

_____ _____

Patient Signature Date

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Patient: _____

Date : _____

LIST ANY PERSONAL MEDICAL OR FAMILY CONDITIONS:

_____

_____

_____

_____

LIST ANY MAJOR OPERATIONS OR HOSPITALISATIONS

_____

_____

_____

_____

LIST YOUR CURRENT MEDICATIONS

_____

_____

_____

_____

Allergies: _____

Name of pharmacy medications collected from: _____

HOW OFTEN DO YOU CONSUME ALCOHOL?

◯ None ◯ Socially ◯ Weekends ◯ 3-4 times weekly ◯ Daily

WHAT IS YOUR CURRENT DEGREE OF CIGARETTE/VAPING USE?

◯ None ◯ Socially ◯ Daily ◯ Ex-use, none currently

ANY SPECIALISTS YOU SEE BESIDES YOUR GP?

_____

_____

_____

WHICH PATHOLOGY LAB DO YOU HAVE BLOODS COLLECTED FROM?

◯ Dorevitch ◯ Melb Path ◯ Australian Clinical Labs ◯ 4 Cyte Other: _____

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ENDOCRINOLOGY
AND METABOLISM

Patient: _____

Date : _____

MEDICAL INFORMATION RELEASE

Often we liaise with external health services to obtain information regarding previously completed investigations and other recorded data. These services usually require express written consent in order to release your health information.

If you would like us to contact other health services and access your past medical files, please fill and sign the form below:

I, _____, (Date of birth_____), consent to the release of all requested medical records and other relevant clinical information to Integrated Endocrinology for the purposes of treatment for my medical condition.

_____ _____

Patient Signature Date