Healthcare Evolutions Medical Group
EVOLVING BETTER HEALTH

MARYLAND MEDICAL PRACTICE ☐
Shop 5 A-C, Maryland Shopping Centre
144 Maryland Drive, MARYLAND,NSW 2287
Ph: 49501333 Fax: 49501444

WALLSEND MEDICAL PRACTICE ☐
Shop 5, Stockland Shopping Centre
Cowper Street, WALLSEND,NSW 2287
Ph: 49512100 Fax: 49512166

CLARENCE TOWN MEDICAL CENTRE ☐
3/ 116 Prince Street, Clarence Town,
NSW 2321
Ph: 49964003 Fax: 49964009

PLEASE FILL OR CIRCLE WHERE APPROPRIATE

First Name: ________________ *Middle Name:* ____________ *Surname:* ____________ *Date of Birth:* __________
Country of Birth: ______________ *Phone:* _______________ *Home:* _______________ *Mobile:* _______________
Medicare Card No: ___________________ *Ref No:* _____ *Expiry Date:* ___________
DVA Card No: ____________ *Expiry Date:* _________ *Email address:* _____________________________________
Pension/ Healthcare Card No: ________________ *Expiry Date:* ____________
Residential Address: ____
Postal Address (if different): ____
Next of Kin: Name: ___________________________ *Relationship:* _______________ *Phone No:* ________________
Address: ____
Emergency Contact: Name: ______________________ *Relationship:* _______________ *Phone No:* ______________
Address: ____
Do you Identify yourself as: **Aboriginal/ Torres Strait Islander/ Australian Non-Aboriginal/ Other:** _________
Smoker: Yes No *Alcohol* Yes No *Allergies:* Yes (*Name:* ______________________________________) No
Marital Status: Single/ Married/ Divorced/ Widowed/ Defacto *Occupation:* _____________________________
Medications: ____
Past History: Diabetes/ Hypertension/ Heart Disease/ Stroke/ Cancer/ Asthma/ Emphysema/ Depression/
Other if any: ____
Family History: Diabetes/ Hypertension/ Heart Disease/ Stroke/ Cancer/ Asthma/ Emphysema/ Depression/
Other if any: ____

Health Information Collection and Use Consent:
We require your consent to collect personal information about you and to use the information you provide in the following ways :-
1.Administrative**. 2.**Billing. **3.**Disclosure to others involved in your healthcare including treating doctors and specialist outside this medical practice. **4.**Other doctors within this practice. **5.**Deidentified for research and quality assurance activities. **6.**To comply with any legislative or regulatory requirements e.g. notifiable diseases. **7.**For reminder letters which may be sent to you regarding your health.

- **Reminder System:** This practice takes a preventative approach to your health. You may receive phone calls, letters or be reminded at your next visit of on-going follow-up for preventative care as well as SMS appointment reminders. If you do not wish to be part of this system, please tick the box, but we strongly recommend this. ☐

- Thank you for taking the time to complete this form.

Signature: ___________________________ **Name:** _________________________________ **Date:** ________________