Doctors on Fifth Marsden
Shop 12, 1-13 Fifth Avenue, Marsden QLD 4132
Ph: (07) 3803 6655 Fax: (07) 3803 7855
Dr Devika Jayawardena MBBS, FRACGP Provider No 257253HX
Dr Tasawar Aslam MBBS, FRACGP, FACRRM Provider No 250366CX

Title: Mr / Mrs / Ms / Miss / Dr / other (please state): _____

Surname: _____ First Name: _____

Preferred Name: (if different to above): _____

Date of Birth: _____ Gender: male / female

Cultural Background: _____ Aboriginal or Torres Strait Islander? Yes / No

Marital Status: _____ Occupation: _____

Address: _____

Suburb: _____ Postcode: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ Email: _____

MEDICARE NUMBER: _____ IRN: _____ EXP: _____ / _____

Pension / HCC (please circle): _____ Exp: _____/_____ / _____

DVA No: _____ White / Gold (please circle) EXP: _____ / _____

Next of Kin: _____Relationship: _____

Contact Number: _____

Emergency Contact: _____ Relationship: _____

Contact Number: _____

How did you hear about us: (please circle) Signage / flyer / internet / walk – by / word of mouth / other: _____

Patient Information Consent

The information is used for the primary purpose of providing quality health care services for your health care needs, this practice has a strict privacy policy on handling patient information. In compliance with the Privacy Act, we require your consent for your treating doctor/s to us the information provided on this form. This and additional information may be provided to other doctors and/or specialist when requesting x-rays, pathology tests, referrals etc. Patient information will not be released to family members without the patients signed/written consent. **Due to Medico-Legal reasons, doctors in this practice will not discuss results over the phone. It is your responsibility to arrange a follow-up appointment for discussion of your results.** By signing this form you are giving consent to contact you by SMS, email, phone or post for our reminder or recall system. I have read the information above and fully understand the consent. I consent to the handling of my information by this practice for the purpose set out above.

You must present your medicare card and any concession cards to reception upon arrival for all consultations. Failure to produce a current valid medicare card may result in a private fee being billed to yourself for your consultation. By signing this form you agree to assign your right to benefits to the Practitioner who rendered the services.

Private Accounts: Payment is required at the time of consultation – No Accounts are given. Failure to pay for you consultation could result in your details being forward to our Debt Collector Agency.

***********if you do not attend your appointment and do not notify the clinic you are unable to attend or cancel your appointment you will be charged a fee of $50.00*********************

Signature:_____ Name _____ Date: _____

Basic Medical History

(When available the nurse will call you in before you see the doctor to go through this information with you – please complete as much as you can)

Name: _____

Date of Birth: _____

Allergies: _____

Medications: _____

Smoking Status: non smoker / ex smoker / smoker Number per day: _____

Do you drink alcohol? Yes / no If yes, days per week? _____ Drinks per day? _____

Current Medical Conditions: _____

Occupation: _____

Family History (ie parents/grandparents):

Diabetes: Yes / No Mother / Father / Grandparents

Heart Disease: Yes / No Mother / Father / Grandparents

Stroke: Yes / No Mother / Father / Grandparents

Hypertension: Yes / No Mother / Father / Grandparents

Depression: Yes / No Mother / Father / Grandparents

Colon Cancer: Yes / No Mother / Father / Grandparents

Breast Cancer: Yes / No Mother / Father / Grandparents

Cancer (please state type): Yes / No Mother / Father / Grandparents

Other: _____

_____

_____

_____

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Office use only:

Seen by: _____

Information entered into computer system: Yes / No Signature: _____

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Consent for My Health Record registration

Name (full name): _____

Date of birth: _____

Sex: _____ M _____ F

Please tick what information (if any) you consent to be included in your My Health Record:

- ☐ Details of all future claims made for medicare benefits when you receive a healthcare service that is covered under the medcare benefits schedule
- ☐ And details of any past claims for medicare benefits – if available (only available if you have ticked above.
- ☐ Details of all future claims made for pharmaceutical benefits when you receive medication that is covered under the PBS
- ☐ And details of any past claims for PBS, if available (only available if you have ticked above)
- ☐ Your organ and/or tissue donation decision from the Australian Organ Donor Register
- ☐ Details of immunisations up to the age of 7, sourced from the Australian Childhood Immunisation Register

Authority:
I declare that:

- The information in this application is correct and any supporting evidence submitted by me is correct
- Consent to records containing my health information being uploaded to the My Health Record system by registered healthcare provider organisations involved in my care, subject to any express advice I give to my healthcare providers not to upload a particular record or a specified class of records

Applicants signature:_____

Date: _____