Edgeworth Family Practice

EDGEWORTH FAMILY PRACTICE IRON INFUSION

□ Mr □ Mrs □ Miss □ Ms □ Master □ Dr

Name_____

DOB _____ / _____ / _____ □ Retired □ Unemployed

Home address: _____ Suburb_____ P/code_____

Mobile number: _____ Work number: _____

Home number: _____ Occupation: _____

I may ask EFP to contact me via email, my address is _____ I confirm I have read the personal information section of the privacy policy □ (please tick)

□ Female □ Male □ Other_____ □ I identify as LGBTIQA+

What country were you born? _____

What country was your Mother born? _____ Please tick if unsure □

What country was your Father born? _____ Please tick if unsure □

Do you identify as (Please tick)
□ Aboriginal □ Torres Strait Islander □ Aboriginal and Torres Strait Islander

Medicare: __ __ __ __ / __ __ __ __ __ /__ Expiry __ __ / __ __ __ __ Number to left of your name- _____

Pension/HCC: __ __ __ / __ __ __ / __ __ __ __ Expiry __ __ / __ __ / __ __ __ __

DVA □ Gold card: __ __ __ __ __ __ __ __ __ Expiry __ __ / __ __ __ __

EMERGENCY CONTACTS

Next of kin Name: _____ Relationship to you: _____

Address: _____

Home ph.: _____ Mobile ph.: _____

Emergency Contact (If different from Next Of Kin) Name: _____

Relationship to you: _____

Address: _____

Home ph.: _____ Mobile ph.: _____

YOUR PRIVACY – PLEASE READ CAREFULLY

This practice collects information for the primary purpose of providing quality healthcare. To confirm we have the correct patient & to check contact details, each time you present/contact our practice you will be asked to confirm 3 points of identification. We require you to provide us with your personal details and relevant medical history so we may properly assess your condition for this procedure. Our clinicians will only request information pertinent to this procedure. Your personal information is handled within the guidelines of the *Privacy Act 1988*. I am a (please circle - **PATIENT** or **PARENT** or **GUARDIAN** or **CARER**) By signing below I am consenting to the collection of my personal information or confirming I have permission to consent on behalf of the abovementioned patient, and confirming I have been issued with a full Privacy Policy to read **(A Practice brochure is attached to the front of this form & a complete policy is attached behind this form)**

PRINT FULL NAME SIGNATURE DATE

EDGEWORTH FAMILY PRACTICE IRON INFUSION

PATIENT NAME: **DATE OF BIRTH** _____ / _____ / _____

CONSENT	DESCRIPTION
APPOINTMENT □ YES □ NO	Consent indicates a patient allows reminders to be sent to them regarding their booked appointment from our appointment book or by an automated service Signed_____ Dated __ / __ / ____

Do you have any Allergies? □ **Yes** □ **No**

Allergic to_____ Reaction _____

Allergic to_____ Reaction _____

Allergic to_____ Reaction _____

Are you on any Medications? □ **Yes** □ **No**

Name of medication	Dosage	Frequency

Do you drink Alcohol? (Please tick)

□ No

□ **Yes-** Days per week? ____ Average drinks per day? ____ □ **Occasional-** Average drinks per session?

Do you smoke? □ Never smoked

□ Past smoker Avg. per day? _____ Year started? _____ Year stopped? _____

□ Current smoker Avg. per day? _____ Year started? _____

□ Cannabis □ No never □ Yes in the past □ Yes currently