Bardon Family Doctors

Shop 3-4 / 50 Macgregor Terrace, Bardon, QLD, 4065
T: (07) 3708 2456
F: (07) 3310 4448
W: www.doctorsinbardon.com.au
E: bardondoctors@gmail.com

Patient Information Form

Please Circle*: Mr Mast Ms Mrs Miss Other:____________________________

Surname*:___________________________________ **First name*:**_______________________________

Middle name: ________________________________ **Preferred name:** _______________________

Date of Birth*: ________/________/________ **Gender:** Male ☐ Female ☐

Address*: ____

Suburb/ City*: _____________________________________ **Postcode*:**____________________

Home phone*: ______________________________ **Mobile phone*:**_____________________________

Work phone: ______________________ **Email:**____

Preferred contact method: ☐ Mobile Ph ☐ Work Ph ☐ Home Ph

Ethnicity*:__________________________________ **Occupation*:**_____________________________
(background- where are you from?)

Are you*: ☐ Aboriginal ☐ Torres Strait Islander

Next Of Kin*: ____
(please write full name)

Phone*: _____________________________________ **Relationship*:** _______________________

Emergency Contact*: ____
(only if different from Next of Kin – if same as Next of Kin write 'As above')

Phone*:______________________________ **Relationship*:**________________________________

Medicare number*:___________________________**Line number:**______ **Expiry:**_________/_________

Pension/ HCC number*: ______________________________ **Expiry:**______/______/______________
(if applicable)
Please circle the type of card: **Pension / Health Care Card**

DVA number: _______________________________________ **Entitlement:** __________________
(if applicable) *(colour/card type)*

Health Insurance number: _______________ Provider: ______________ **Expiry:**____/____/_______
(if applicable)

Are you allergic to any medications? Yes / No
If so, please list them: ____
Do you have other family members attending this clinic? If so, please list them:

____

I give my consent to be part of the practice's recall and reminder system.

____
(please sign here - if patient cannot sign, parent/guardian signature required)

We are committed to provide you with the best of care. To do this it is essential that your medical records are kept up to date and accurate. All details are strictly confidential. Please advise us if any of the above details change, most importantly address, phone/ Medicare number. Thanks for your co-operation.