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E info@erahealth.com.au
W www.erahealth.com.au

PERSONAL DETAILS

Title: _____ Surname: _____

First Name: _ _____D.O.B. ____ /____/_____

Address: _____

Suburb: _____ Post Code: _____

Tel: H: _____ M: _____

Email: _____

Marital Status: _____

Occupation: _____

Employer: _____

Country of Birth: _____

Background/Primary Language: _____

Are you of Aboriginal or Torres Strait Island descent?

YES / NO If YES: _____

Medicare Number: _____

Reference Number (in front of name): _____ Expiry Date: _____/_____

Private Health Insurance: YES / NO

If YES, name of fund: _____

Membership Number: _____

Pension/Centrelink/Veterans Affair card Number:
_____ exp: ____/_____

TAC/Work cover (circle) Claim no: _____

EMERGENCY CONTACT: _____

Relationship: _____ Tel: _____

Next of Kin (if different from above):

_____

Relationship: _____ Tel: _____

How did you hear about us? (please circle)

Word of Mouth Google Search Signage

Employer Health Fund

Brochure/Flyer Other (please specify): _____

FAMILY HISTORY

Has any member of your family ever been diagnosed with diabetes, cancer or a heart condition? If yes, please specify:

_____

_____

PAST MEDICAL HISTORY

Have you ever been admitted to hospital? If yes, please provide date and reason: _____

_____

ALLERGIES: Are you allergic or sensitive to any medications:

YES / NO If YES:_ _____

Are you diabetic: YES / NO If YES, Type 1 or Type 2 (circle)

Do you suffer from high blood pressure: YES / NO

Have you ever suffered from chest pain or shortness of

breath? YES / NO

Women Only: When was your last Pap smear: _____

Do you smoke: YES / NO If YES, how many per day? _____

If you previously smoked, when did you quit? _____

Do you drink alcohol: YES / NO

If YES, how many days per week? _____

CANCELLATION POLICY

ERA Health require at least 12 hours notice to cancel or change an appointment. Failure to provide this notice may result in a cancellation fee being charged.

PRIVACY & CONSENT

Era Health complies with the Privacy ACT (1988) and is committed to protecting the privacy of individuals and their personal information. I have read and understood the above and provide my consent to Era Health for the collection, usage, storage and disposing of my personal information; the release of relevant personal information to other health professionals for medical care; the inclusion in the practice' s recall and reminder systems, medical updates and information newsletter. I understand that I may withdraw my consent to Era Health to use and disclose my personal information at any time (except when legal obligations must be met). I acknowledge that the information given on this form is true and accurate to the best of my knowledge.

Signature: _____

Date: _____