Epping Road Family Clinic
Shop 2/80h Epping Road
Epping, VIC 3076

Patient Information Form

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate.

Please assist us by completing the fields below

Title	◯ Dr. ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss ◯ Master	
Ethnicity	◯ Aboriginal ◯ Torres Strait Islander ◯ Other (please specify): ◯ Aboriginal & Torres Strait Islander	
First Name:	**Surname:**	**Preferred name:**
Gender:	**Marital Status:**	**Occupation:**
Date of Birth:		
Street address:		
Suburb and postcode:		
Home phone:		
Mobile number:		
Email address:		
Medicare number/reference:	/ Expiry date:	
DVA Gold:		
DVA white:		
Pension Card	Number:	Expiry date:
Healthcare Card	Number:	Expiry date:
Private health cover name and number	Name: Number:	
Next of kin **Emergency contact details**	Name: Number: Relationship: Name: Number: Relationship:	
Medical history	☐ Diabetes ☐ Asthma ☐ Hypertension ☐ Chronic illness (Please specify) ☐ Other (Please specify)	
Allergies	◯ No ◯ Yes (Please specify):	
If completing this for a child: Is he/she up to date with his/her immunisations?	◯ Yes ◯ No	
(ÅÁÌôÈ 2ÅÃÏÒÄÓ	Weight: Kg Height: cm	Smoking ◯ Yes ◯ No Alcohol ◯ Yes ◯ No
Please list your current medication/s below with frequency and dosage		
1.	**Dosage:**	**Frequency:**
2.	**Dosage:**	**Frequency:**
3.	**Dosage:**	**Frequency:**
4.	**Dosage:**	**Frequency:**

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