The Park Medical Centre

ABN 81 077 919 343

Inner Sole Pty Ltd t/as The Park Medical Centre

Shop 4, Street Level, 27 Park Street,
Sydney N.S.W. 2000 Australia

All Mail To: PO Box A211, Sydney South NSW 1235

Phone: (02) 9264 4488
Fax: (02) 9264 4047
Email: parkmedcentre@internode.on.net

Patient's Full Name: (Mr Mrs Ms Miss Mst)________________________________
Male/Female
Date of Birth _____/_____/________ Ph: ________________ Wk: _______________
Mob: __________________
Residential Address
Street: ______________________________ ____Suburb: _____________Postcode: _________
(Number & Name)
Postal Address if different from above
PO Box: _______________________________Suburb: _______________Postcode: _________
I wish to receive e-mail reminders or newsletters in the future, by providing my e-mail address I am consenting to this use.
My e-mail address is ____
Please write clearly & in the appropriate case UPPER or lower.
Private Hospital insurance Yes/No Basic Hospital Intermediate Top Hospital
Do you require a translator Yes/No Preferred
Language_____________________________?
Emergency contact full name: ____________________________
Relationship: ________________Ph:____________
If we need to contact you with results or to change an appointment, how would you prefer we do this?
(Home Phone, Work Phone, Mobile, Letter) Other_____________________
Preferred number ____________
Do you authorise messages to be left for you at this number where the surgery is identified as the caller? YES/NO
How did you choose this surgery? (Location, Yellow Pages, referred by friend/relative)
Other____________________
Person responsible for account (who will pay) e.g. Self
____
Payer's Address (if different from above)
____Phone: ______________
It is the policy of this practice that all accounts are paid at the time of consultation; EFTPOS is available

Medical History
PLEASE CIRCLE – PLEASE ANSWER ALL QUESTIONS
Aboriginal or Torres Strait Islander Yes/No
Pension/Health Care Card Yes/No
Smoker Yes/No Number of cigarettes/day _______

Current Medications Yes/No
Please list____
Allergies Yes/No Please list____
***Please make sure you tell the Doctor about any allergies you may have or any medications you are taking, including vitamins PTO**

Medical History cont.
Has the patient ever had problems with: Blood pressure yes/no
Date_________________
Please include an approximate date Cholesterol yes/no Date_________________
or time frame where possible. Blood glucose yes/no Date_________________
Diabetes yes/no Date_________________
Heart ailments yes/no Date_________________
Asthma yes/no Date_________________
Has anyone in the patient's family had: Heart problems yes/no
_______________________ (details)
Relationship i.e. Mother, Father,
Brother, Sister Stroke yes/no________________________ (details)
Diabetes mellitus yes/no________________________ (details)