

T: 07 3450 3704 | **F: 07** 3450 3705 14 Brighton Road, Macleay Island, Qld, 4184 info@mimc.net.au

☐ Mr ☐ Master	First Name (legal name)	Surname (legal name)		
□ Mrs □ Ms □ Miss				
- Wild - Wild - Wilds				
Preferred Name:		Date of Birth:	Date of Birth:	
r referred Name.				
I identify my gender as:		Are you Aboriginal? Y	es / No	
□ Male □ Female □ Trans		-	Are you Torres Strait Islander? Yes / No	
		-	Are you Aboriginal & Torres Strait Islander? Yes / No	
ETHNICITY: (Country of Birth)		7.1.0 you 7.1.011gu. u. 101		
STREET Address: Ho		Home Phone:	ome Phone:	
		Mobile Phone:		
Do you consent to receiving SMS reminders? ☐ Yes ☐ No				
Medicare Number			Expiry	
medicare rumber				
Health Care / Pension Card/DV	A			
Number			Expiry	
(Please circle if applicable)				
Next of Kin	•	Emergency Contact	Same as Next of Kin □	
Full Name Full N		Full Name		
Phone Relationship Phone		Phone Rela	e Relationship	
			•	
Do you have any allergies or are you sensitive to drugs or dressings, foods?				
□ No – no known allergies □ Yes – please describe:				
Smoking history: Non-smoker Yes per day ex-smoker quit date:/				
Alcohol history: ☐ Non-	drinker ☐ Yes (please circle)	Light Moderate Heavy		
Alcohormically. Li Non-	armici — i es (piedse circle)	Light moderate fleavy		
Weight: Height:				
Important Disclosure:				
☐ I have read and understand the laminated privacy statement at the back of this clipboard.				
☐ I understand this clinic will not discuss any results over the phone. All patients <u>must</u> return to the clinic for test results.				
□ i unuerstanu triis ciinic Will	not discuss any results over the phor	ie. Ali patients <u>inust</u> retum to the C	mino ioi lest lesuits.	
Patient / guardian Signature: Date: / /				