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

☐ Mr ☐ Master ☐ Mrs ☐ Ms ☐ Miss	**First Name (legal name)**	**Surname (legal name)**
Preferred Name:		**Date of Birth:**
I identify my gender as: **☐ Male ☐ Female ☐ Trans** **ETHNICITY: (Country of Birth)**		**Are you Aboriginal? Yes / No** **Are you Torres Strait Islander? Yes / No** **Are you Aboriginal & Torres Strait Islander? Yes / No**
STREET Address:		**Home Phone:** **Mobile Phone:**
Do you consent to receiving SMS reminders? ☐ Yes ☐ No		
Medicare Number	☐☐☐☐☐☐☐☐☐ -☐ Ref ☐	**Expiry**
Health Care / Pension Card/DVA Number (Please circle if applicable)		**Expiry**
Next of Kin **Full Name** **Phone** **Relationship**		**Emergency Contact** **Same as Next of Kin ☐** **Full Name** **Phone** **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

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 **must** return to the clinic for test results.

Patient / guardian Signature: ____ Date: / /