



# Emerald Medical Centre St Marys

65A Queen St, St Marys NSW 2760

Ph: 02 9833 7211 Fax: 02 9833 7299

Email: [emcstmarys@gmail.com](mailto:emcstmarys@gmail.com)

Website: [emeraldmedicalcentre.com.au](http://emeraldmedicalcentre.com.au)



Title: \_\_\_\_\_ Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation: \_\_\_\_\_

Contact Numbers: Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Marital Status:**  Single  Married  Defacto  Separated  Divorced  Widow

**Emergency Contact:** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph Number: \_\_\_\_\_

**Are you Aboriginal or Torres Strait Islander Origin?**

- Yes Aboriginal  Yes Aboriginal and Torres Strait Islander  
 Yes Torres Strait Islander  No

**Allergies:** Do you have any Allergies?  Yes- Please Specify \_\_\_\_\_  
Reaction: \_\_\_\_\_  
 Nil Known

**Smoking:** Tobacco Status: Do you Smoke Tobacco?  Yes- Number of Cigarettes per Day: \_\_\_\_\_  
 Ex-Smoker-Quit Date: \_\_\_\_\_  
 No

Do you use any Other Drugs?  Yes-Please Specify: \_\_\_\_\_  
 No

**Alcohol Status:** Do you consume Alcohol?  Yes- If yes please indicates below.  No.

Number of Standard Drinks consumed when you do drink? \_\_\_\_\_  
How often are they Consumed?  1-2 Days a Week  3-4 Days a Week  5-6 Days a Week  
 Everyday  1-2 Days a Month  Less than Monthly

Please Note if you do not feel comfortable indicating any of the above details on this form, please inform the Doctor while in consultation.

Medicare Number: \_\_\_\_\_ Ref: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Pension Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Type of Pension Card:  Centre Link Health Care  Centre Link Pensioners Concession  Common Senior Health  Other: \_\_\_\_\_

For each consultation, I offer to assign my rights to Medicare Benefit payable to the Doctors at Emerald Medical Centre St Marys, who will render the Medical Service. I am aware of my rights to access my Medicare information from Emerald Medical Centre St Marys, which will be made available upon my request with adequate notification time. If the information is not readily available, I understand I will be given an explanation in these circumstances.

**Signature x:** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_