

Dr Phillip R Loxley M.B.,B.S.(NSW) 3 Adelong Street
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We are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

Could you please assist us by completing the following?

Surname	Mr / Mrs / Miss / Ms / Dr		
First Name			
Date of Birth:			
Street Address			
Suburb and Post Code			
Home Phone			
Work Phone			
Mobile Phone			
Email			
Medicare Number	1 2 3 4 5 6 7	Expiry Date	
Patient Ref No:	Please circle		
DVA Gold / White		Expiry Date	
Pension Number		Expiry Date	
Health Care Card Number		Expiry Date	
Private Health Cover			
Next of Kin (Name and Phone number)			
Emergency Contact & Phone number			

SMS reminders Yes / No

Your Health History - Do you have or had a history of?

Operations _____
 Asthma Yes / No Hypertension Yes / No
 Chronic illness Yes / No Diabetes Yes / No

Do you have any allergies or are you sensitive to drugs or dressings:

Nil known Yes (If yes please list below)

Have you had an Influenza vaccination Yes / No / Unsure **Date of vaccination**
Have you had a Covid Vaccination Yes / No / Unsure **Date of vaccination**