



COVID19 Vaccination Patient Form

Title _____ First Name: _____ Surname: _____

Date of Birth: _____

Address: _____

Suburb: _____ Post code: _____

Home Tel: _____ Work Tel: _____ Mobile Tel: _____

Medicare Number _____ Ref [i.e. number next to your name] _____ Expiry date _____

Email: _____

Emergency contact name: _____ Relation: _____

Contact number: _____

Are you of Aboriginal and/or Torres Strait Islander origin? No Aboriginal Torres Strait Islander Both

Country of Birth: _____ Native Language: _____

Do you suffer from any allergies? NO YES:

If YES, please list your allergies: _____

MEDICATIONS: please list your current medications here:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PRIVACY:

Premier Medicine use a computerised medical record system. We take all precautions necessary with our computer system security and when emails or SMS correspondence are sent. NB: In the unlikely event of a security breach, your electronic information could be compromised.

This practice sends out SMS and/or emails for recalls, reminders, correspondence, and copies of results/reports. Do we have your permission to use these forms of communication for correspondence: Yes No

Please note: should you wish to attend our practice at a later date, for non-COVID19 vaccination related services, you will be provided a full list of our fees and charges, which are also available on request.

Patient signature _____ Date _____