Sydney Gastroenterology

Today's Date:____________

Patient Information

Title: Dr/Mr/Mrs/Ms/Miss/Master *(please circle one)* Date of Birth: ______________

Surname: ____ Given Name(s) ____

Address: ____Suburb: ___________________________ Postcode: _________

Home Tel: _____________________ Work: ______________________ Mobile: ________________________

(Please provide at least two (2) telephone numbers for contact purposes) Email:____

Gender: M / F *(please circle one)* Occupation: ________________________________ Marital Status:_____________________

Country of Birth: ______________________________ Language(s) Spoken at Home: _____________________________________

Emergency Contact or Next of Kin *(NoK)*:: ______________________________________ Relationship to You: _______________

Emergency Tel: ________________________________ Is this person authorised to discuss your medical information? Yes / No

Next of Kin *(if not above)*: _______________________________________ Relationship to You: ____________________________

Next of Kin Tel: ________________________________ Is this person authorised to discuss your medical information? Yes / No

Medicare Number: ______________________________________ Reference Number: _______

Private Health Fund: _____________________________________Member Number: ______________________________

Date Joined if Less Than 1 Year: _______ Veterans Affairs Number: ___________________ Pension Card #:________________

Referring Doctor: _______________________________________ Suburb: _______________________________________

Tel: ___________________________

GP *(if not referring doctor)*: __________________________________ Suburb: _______________________________________

Tel: ___________________________

Preferred location for procedure(s) - you may choose more than one:

__ Chris O'Brien Lifehouse/RPA (Private) __ St George Private Hospital (Private) __ Macquarie University Hospital (Private)

__ Liverpool Day Surgery (Private) __ Concord Hospital (Private & Public) __ Bankstown Public Hospital (Public)

Consent to Collect Patient Information

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal deta·i1s and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

- I understand the reasons why my information must be collected.
- I consent to the practice collecting information relevant to my condition from other medical practitioners such as GPs, specialists, health care providers, pathologists, radiologists, hospitals or day surgeries.
- I understand that I am not obliged to provide any information requested of me, but that not doing so might compromise the quality of the health care and treatment given to me.
- I am aware that I may apply to access my health records.
- I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

To comply with the Privacy Act 2001, all patients need to provide consent for the above aspects of their medical care. Staff are bound by strict confidentiality requirements. Please be aware that we only keep scanned computer generated copies of your original documentation. If you require return of your original documents please advise reception staff at the time of your appointment. All non-returned original documents will be disposed of securely within 24 hours of your appointment.

Patient Signature: ____ Date:_________________