Sydney Gastroenterology

If you have any queries regarding this form, please call (02) 9707 3523

FAX TO
(02) 9709 5637

EMAIL TO
reception@sydneygi.com.au

PATIENT INFORMATION

Today's Date ____ / ____ / ____

Title (please circle one) Dr / Mr / Mrs / Ms / Miss / Master D.O.B. ___ / _____ / _____

Surname _____ Given Name(s) _____

Street Address _____

Suburb _____

Postcode _____ Home Tel. _____ Work Tel. _____ Mobile _____

(please provide at least two telephone numbers for contact purposes) Email _____

Gender (please circle one) M / F 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 _____

Emergency Tel. _____ Is this person authorised to discuss your medical information? Yes / No

Medicare Number _____ Reference Number _____

Medicare Expiry Date _____

Private Health Fund _____ Member Number _____

Date Joined if Less Than One Year _____ / _____ / _____

Veterans Affairs Number _____ Pension Card # _____

Referring Doctor _____ Suburb _____

Tel. _____

GP (if not referring doctor) _____ Suburb _____

Tel. _____

Patient / Guardian Signature _____ Date _____ / _____ / _____

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COLLECTION OF PERSONAL 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 details 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:

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

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. Please be aware that we do not routinely send correspondence and reports to My Health Record.

COMMUNICATION BY EMAIL

Sydney Gastroenterology offers patients the opportunity to communicate by email for non-urgent administrative matters.
Please find below the risks and guidelines for email communication.

Communication by email has a number of risks which include, but are not limited to, the following:

- Email can be circulated, forwarded and stored in paper and electronic form.
- Back up copies of email may exist even after the sender or recipient has deleted his/her copy.
- Email can be received by unintended recipients.
- Email can be intercepted, altered, forwarded or used with authorisation or detection.
- Email can be used to introduce viruses into computer systems

Guidelines for Communication

- Include the general topic of your message in the subject line of your email (eg appointment)
- Include your name, date of birth and phone number in the email
- Email should be used for non-urgent administrative issues only.
- It is your responsibility to notify Sydney Gastroenterology of any changes to your email address
- Sydney Gastroenterology will try to respond as soon as possible but not within any particular timeframe

COMMUNICATION BY SMS

Sydney Gastroenterology offers patients the opportunity to receive non-urgent administrative SMS messages for appointment reminders, recalls and other reminders or medical services we offer. It is your responsibility to notify Sydney Gastroenterology of any changes to your mobile phone number.

PATIENT CONSENT

1. I understand the reasons why my personal information must be collected.
2. 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.
3. 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.
4. I am aware that I may apply to access my health records.
5. 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.
6. I understand the risks and guidelines associated with email and agree to give consent for email communications to and from Sydney Gastroenterology
   ◯ Tick this box if you DO NOT agree to receive emails from us
7. I understand and agree to give consent to being contacted via SMS (mobile text message)
   ◯ Tick this box if you DO NOT agree to receive SMS messages from us

Patient / Guardian Signature _____ Date _____ / _____ / _____