SouthWest SURGERY

5 Ramsay Street Bunbury WA 6280
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Patient Information Form

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Prof ☐ Other _____

Given Name: _____ Surname: _____

Preferred Name: _____ Date of birth _____

Address: _____ Suburb: _____ Postcode _____

Email: _____ Phone: (H) _____ (W) _____ Mobile: _____

Weight: _____ Height: _____

Medicare No. ☐☐☐☐☐☐☐☐☐☐ Ref No. ☐ Expiry Date ☐☐ / ☐☐☐☐

Dept. Veterans Affair Card No: _____ ☐ White ☐ Gold Expiry Date _____

Concessions: ☐ None ☐ Pensioner Entitlements No. _____ Expiry Date _____

Private Health Insurance:

☐ Yes ☐ No Fund: _____ Fund Number: _____

Hospital Inpatient Cover: ☐ Yes ☐ No

Who is responsible for your account?

☐ Self ☐ Parent ☐ Vet Affairs ☐ Workers Compensation ☐ MVIT

Workers Compensation:

Employer _____ DOA: _____

Insurance Company: _____ Claim No. _____

Next of Kin Details/ Emergency Contact Name

Name: _____ Relationship to you _____

Contact number: _____

Referral Source

☐ Doctor-GP ☐ Specialist ☐ Emergency department

Referring Doctor: _____ Date of referral: _____ Usual GP: _____

Do you have/or have had any of the following conditions or illnesses

Cancer related illness	☐ Yes	☐ No	Type: _____
Diabetes	☐ Yes	☐ No	Type: _____
Blood clots or bleeding problems	☐ Yes	☐ No	Type: _____
Kidney condition	☐ Yes	☐ No	Type: _____
Bladder problems	☐ Yes	☐ No	Type: _____

PLEASE TURN OVER THE PAGE

Heartburn or acid reflux ☐ Yes ☐ No Type: _____

Hepatitis or liver problems ☐ Yes ☐ No Type: _____

Epilepsy, blackouts or stoke ☐ Yes ☐ No Type: _____

Do you drink alcohol? ☐ Yes ☐ No Number per day: _____

Do you smoke cigarettes? ☐ Yes ☐ No Number per day: _____

Have you ever smoked? ☐ Yes ☐ No If yes, when did you stop: _____

Do you use or have you used recreational drugs? ☐ Yes ☐ No Type: _____

Frequency: _____

Do you have, or have you been at risk of AIDS or hepatitis? ☐ Yes ☐ No Type: _____

Do you have illnesses run in your family? ☐ Yes ☐ No

Describe:

Privacy Information and Consent Form

The law gives you certain privacy rights in relation to information that you give to this practice. We need your consent to collect personal information about you.

We will also use the information you provide in the following ways:

- Administration of this medical practice (by all practice staff).
- Billing, including Medicare and health insurance commission requirements.
- Disclosure to others involved in your health care (electronically via health link/faxed/emailed or written) including doctors and specialists outside this practice, who may become involved in your care. This may occur through referral to others doctors, or for medical tests, and in the return of results and reports from these referrals.
- Disclosure to others for medical defence purposes if necessary.
- Disclosure for multidisciplinary, audit, teaching, research, quality assurance activities to improve individual and community health care and practice management.
- I consent for messages to be left on the contact numbers I have provided.
- Photographic library may be used for record, teaching and educational purposes.

I consent to images taken during my consult to be used anonymously for advertising and educational purposes.

☐ **Yes** ☐ **No**

Patient's Acknowledgment

I have read this form and understand:

- Why collecting information about me is necessary.
- I am not obliged to provide any information requested to me.
- My failure to provide this information may restrict the practice's ability to provide the quality of health care and treatment that I want.
- I have the right to access the information collected about me, except in some circumstances where access might legitimately be withheld. Fee's may be applicable for the collection of such information and adequate ID is required to receive this information.
- If my information is used for any other purpose other than set out above, my further consent will be obtained.
- I have the right to used an alternative name/pseudonym and are aware this can be impractical for Medicare purposes and accessing my medical history.

PLEASE TURN OVER THE PAGE

I am responsible for my accounts until settled in full (by myself or my health fund). The information you give to us is essential for administration, investigations, management of your health and audit purposes. This information will be kept confidential in electronic format and will not be used for any other purpose or released to any individual or organisation, from that otherwise stated without your written consent as per the practice privacy policy displayed.

I understand that any gap payment not covered by my health fund or any surgical procedure will be paid by myself prior to my surgical date.

I acknowledge that I have read this form before signing it and that a member of staff has clarified any aspects I have not fully understood.

I consent to the handling of my information by this practice for the purposes set out above.

I acknowledge that I have read this form before signing it and that a member of staff of this practice has at my request clarified any aspects of it that I did not understand.

Patient Name: _____ Signature: _____

Date: _____