

## PATIENT INFORMATION

TITLE: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ KNOWN AS \_\_\_\_\_ SURNAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ SUBURB: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ EMAIL: \_\_\_\_\_

PHONE: Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

MEDICARE NO: \_\_\_\_\_ REF NO\*: \_\_\_\_\_ EXPIRY DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

\* (The number directly in front of your name)

HEALTH FUND: \_\_\_\_\_ MEMBERSHIP NO: \_\_\_\_\_

PENSION CARD NO: \_\_\_\_\_ EXPIRY DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

VETERANS AFFAIRS NO: \_\_\_\_\_ CARD COLOUR: \_\_\_\_\_

SPECIALIST: (Please circle)    DR FRANCIS LAM    DR MARK MUHLMANN    DR BILL BYE    DR EMILY HE

REFERRING DOCTOR: \_\_\_\_\_ CLINIC & SUBURB: \_\_\_\_\_

USUAL GP (Family Doctor): \_\_\_\_\_ CLINIC & SUBURB: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ MOBILE: \_\_\_\_\_

### **ARE YOU TAKING ANY MEDICATIONS THAT THIN THE BLOOD? (If so, please list/circle)\***

Asasantin   Aspirin / Cartia   Astrix   Cardiprin   Coumadin / Warfarin   Eliquis / Apixaban   Fish Oil / Krill Oil

Gingko Biloba   Pradaxa / Dabigatran   Plavix / Co-Plavix / Clopidogrel / Iscover   Xarelto / Rivaroxaban

### **ARE YOU DIABETIC? (Please circle)\*   NO   or   YES (TYPE I / TYPE II)**

Jardiance   Jardimet   Qtern   Glyxambi   Steglarto   Segluromet   Steglujan   Forxiga   Xigudo XR   Invokana

Diabex   Diaformin   Metformin   Diamicron   Januvia

**OTHER MEDICATIONS TAKEN:** \_\_\_\_\_

**DRUG OR FOOD ALLERGIES:** \_\_\_\_\_

### **Privacy Statement and Consent**

As a patient of Sydney Colorectal Associates a medical record containing personal information will be maintained throughout your treatment. These records will contain information including, but not exclusive to, your name, address, date of birth, Medicare number and your referring doctor's details. During the period of assessment and ongoing management, information of relevance is recorded in clinical notes. These records are stored securely and may be kept for up to seven years following your last consultation. If necessary, for the continuity of your medical care, this information may be shared with other health practitioners involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information. A full copy of our privacy policy is available on request.

I hereby give my permission for Sydney Colorectal Associates to pass on and to seek medical information from any medical practitioner, who has referred, treated or will treat me as long as the exchange of information is necessary for my medical treatment. I give my permission for Sydney Colorectal Associates to undertake tissue banking of pathology specimens from any procedures I may need to undergo; (de-identified) photography/recording of procedures I may need to undergo for educational, clinical and audit purposes; presentation of my (de-identified) clinical facts at educational or scientific meetings and in journals; and/or presentation of my (identifiable and linkable) clinical facts and discussion at multidisciplinary meetings that are presented for the purpose of optimising my clinical management.

I also give my permission for Sydney Colorectal Associates to use Medicare Online Claiming and/or electronic account transmission on my behalf when required, and I assign my right to Medicare benefits to the Practitioner who rendered the service/s.

I also give my permission for Sydney Colorectal Associates to send correspondence by post/SMS/email to help me maintain my health.

I acknowledge and understand that if there are any changes to the information provided above, it is my responsibility to inform Sydney Colorectal Associates to help me protect my privacy.

I acknowledge and understand that there may be out-of-pocket costs for services provided and that it is my responsibility to confirm with Medicare and/or my insurer (if any) as to my eligibility and the amount of any reimbursement, and if a procedure is necessary during my consultation, there may be an associated cost in addition to the standard consultation fee.

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_