PATIENT INFORMATION

TITLE: ____ FIRST NAME: _____KNOWN AS _____SURNAME: _____

ADDRESS: _____SUBURB_____ POSTCODE: _____

DATE OF BIRTH: _____/_____/_____ EMAIL: _____

PHONE: Home: _____Mobile: _____ Work: _____

OCCUPATION: _____

MEDICARE NO: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **REF NO:** __ (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
ALLIED HEALTH: (Please circle) ROBYNNE JEFTHA RACHEL MALONE

REFERRING DOCTOR: _____ CLINIC & SUBURB: _____

USUAL GP (Family Doctor): _____ CLINIC & SUBURB: _____

NOK / 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 Jardiamet Qtern Glyxambi Steglarto Segluromet Steglujan Forxiga Xigudo XR Invokana
Diabex Diaformin Metformin Diamicron Januvia Ozempic

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.

I consent to a cancellation fee of $50 for a consultation and $200 for a procedure if I cancel with less than 48 hours' notice or do not attend. I understand these fees are not eligible for Medicare rebates, and future bookings may be restricted until the fee is paid.

Signature: _____

Name: _____ Date: _____/_____/_____