LAST NAME: …….. … Mr/Mrs/Miss/Ms

GIVEN NAMES: ……...

DATE OF BIRTH: ……AGE: ……

ADDRESS:…….

……..POST CODE: ……..

EMAIL ADDRESS: ……

TELEPHONE: Home: ……. Work: ……... Mobile: ……

NEXT OF KIN:**…… Relationship: ……..... Contact No.: ……..

****Different phone no.**

REFERRING DOCTOR: ……..Referral Date: ……...

GP: …….

DO YOU HAVE PRIVATE HEALTH INSURANCE? Yes / No

NAME OF FUND:……Membership No.: ……

MEDICARE: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

PENSION or HEALTH CARE CARD or DVA No.: ……..

REASON FOR REFERRAL: ……

……...

PAST OPERATIONS: ……...

……...

OTHER MEDICAL CONDITIONS / ? PACEMAKER / ? GASTRIC LAP BAND: …….

……...

APPROXIMATE WEIGHT IN KG: ……. HEIGHT: ……..

CURRENT MEDICATIONS / BLOOD THINNERS: …….

……...

……...

ALLERGIES (to drugs or latex): ……..

DO YOU SMOKE? Yes / No If yes, how many per day? ……...

DO YOU DRINK ALCOHOL? Yes / No If yes, how much per day / week? ……..

PAST ILLNESS:

	YES	NO		YES	NO
HEART ATTACK	☐	☐	STROKE:	☐	☐
HEPATITIS	☐	☐	RHEUMATIC FEVER	☐	☐
ASTHMA	☐	☐	HIGH BLOOD PRESSURE	☐	☐
DIABETES	☐	☐	DVT	☐	☐

DO YOU USE INSULIN / DIABETIC TABLETS? ……..

PTO ⇨

CONSENT FORM

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

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 a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors or for medical tests and in the reports or results returned to us following the referrals.

The practice undertakes training of students and some research activities; the following clauses need to be read.

- Disclosure to you the patient, other doctors in the practice, locums and Registrars attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes and we will note your record accordingly.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.

.....

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

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 that I notify this practice of.

_____ DOB: _____
PRINT NAME

Signed: _____ Date: _____

PENINSULA GASTROENTEROLOGY
26 HAIG ST, MORNINGTON VIC 3931.