**PATIENT INFORMATION**

TITLE: \_\_\_\_\_\_\_\_\_\_\_ SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POSTCODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE: Home: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give my consent to letters and results being emailed to me Yes / No

**EMERGENCY CONTACT:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE: Home: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

NAME OF HEALTH FUND: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEMBERSHIP NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GP (Family Doctor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ARE YOU DIABETIC? YES / NO**

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

**Have you ever had a gastroscopy (endoscopy) or colonoscopy? \_\_\_\_\_\_\_\_ If so, please give dates \_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever smoked? \_\_\_\_\_\_\_ Do you still smoke? \_\_\_\_\_\_\_**

**How many standard drinks of alcohol would you drink per day? \_\_\_\_\_\_\_ or week? \_\_\_\_\_\_\_\_\_**

**Privacy Statement**

As a patient of Dr Matthew Hall / Dr Jason Behary / Dr Vanessa Rees 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 Dr Matthew Hall / Dr Jason Behary / Dr Vanessa Rees 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 Dr Matthew Hall / Dr Jason Behary / Dr Vanessa Rees to undertake (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 Dr Matthew Hall / Dr Jason Behary / Dr Vanessa Rees 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.

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

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