Dr Douglas Samuel

Gastroenterologist & Consultant Physician

Patient Details Form

Mr /Mrs /Ms /Miss /Other _____ _____

Title (Circle one) **Given Names** **Surname**

Known As (if different than above) _____ Date of birth _____

Street Address _____ **Home Phone** _____

Suburb _____ **Work Phone** _____

State _____ **Postcode** _____ **Mobile** _____

Email _____ **(address to which you consent to be contacted electronically)**

Medicare No. _____ **Reference on card** _____ **Expires** _____

Private Health Fund_____**Membership No.** _____ **Ref.** _____

Health Care/Pension/DVA Card (circle one) Number _____**Expires** _____

Your profession: _____ **Are you of Aboriginal or Torres Strait Islander origin? A** ☐ **TSI** ☐ **both** ☐

Next of Kin/Contact person _____**Telephone**_____

Next of kin's relationship to patient (are they your mother, father, partner, friend or other?) _____

Referring Doctor's name _____ **Suburb** _____

Your usual GP (only if different than your referring doctor above):

Name Practice name or Suburb Phone

_____

Are there other medical practitioners you would like correspondence to be sent to, apart from your referring doctor and usual GP?

Name Address Phone

_____

If you request a video consultation: Can you get access to internet and Skype or a webcam? Yes / No

CONSENT TO COLLECT PATIENT INFORMATION

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

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

- I understand the reasons why my information must be collected.
- I consent to the practice collecting information relevant to my condition from other medical practitioners such as GPs, specialists, health care providers, pathologists, radiologists, hospitals or day surgeries.
- I understand that I am not obliged to provide any information requested of me, but that not doing so might compromise the quality of the health care and treatment given to me.
- I am aware that I may apply to access my health records.
- I understand that if my information is to be used for any purpose other than the above, my consent will be sought.
- 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 of which I may notify this practice.

To comply with the Privacy Act 2001, all patients need to provide consent for the above aspects of their medical care. Staff are bound by strict confidentiality requirements. Please be aware that we only keep scanned computer generated copies of your original documentation. If you require return of your original documents please advise reception staff at the time of your appointment. All non-returned original documents will be disposed of securely within 24 hours of your appointment.

Patient's Signature Date