OCEANSIDE UROLOGY

Dr Stuart J Collins
BSc MBBS FRACS (Urol)
Urological Surgeon

PATIENT INFORMATION FORM

Patient details		
Surname		
Given Names		
Date of birth		
Home address		
Postal address		
Telephone (H)	(W)	(M)
Email address		

Emergency contact information	
Name	Relationship
Address	
Telephone	

Medical History (Do you have any medical issues?)

Surgical History (Please list any previous operations)

Medications (including health supplements) dosage and time of day	
Do you take blood thinners?	

Social History	
Occupation	
Alcohol intake (drinks per week)	
Cigarettes (cigarettes per day)	How many years?
Allergies	
Height	Weight

Medicare and Private Health Insurance	
Medicare number	Expiry date
Private health insurer	
Insurance number	
Referring Doctor	

PRIVACY CONSENT

We require your consent to collect personal information about you. Please read this 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 personal details and a full medical history to enable us to properly assess, diagnose 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 this medical practice (this may include telephone, email and SMS contact)
- Billing purposes, including compliance with HIC requirements (Medicare)
- Disclosure to others involved in your health care, including treating Doctors and Specialists outside of this practice. This may occur through referral to other Doctors.
- Disclosure to Doctors performing locum sessions within this Practice.

If you have any questions in relation to any of the above matters, please raise these with your Urologist.

I have read the information above and understand the reasons why my information must be collected. I am aware that this practice has a Privacy Policy in regard to handling of patient information.

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

I am aware of my right to access information collected about me, except in some circumstances where access might legitimately be withheld. I understand that 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 that set out above; my further consent will be obtained.

I consent to the handling of my information by my Urologist or staff for the purposes set out, subject to any limitations on access or disclosure that I have given notification of.

If deemed necessary, I consent to my doctor taking digital photographs and/or video for my health record. These photographs and video may be use for teaching or presentation purposes. All patient information will be de-identified. This consent can be withdrawn at any time.

Print Name……

Signed……

Date……