riverina
endovascular

PATIENT INFORMATION SHEET

Mr /Mrs /Ms/Miss/Master Surname: ______________________________

Given Name: ______________ Second Name: ______________

Address: ______________________________

______________________________ Postcode: __________

DOB: __________ Telephone: Home: __________ Mobile: __________

Email: ______________________________

Next of Kin : __________ Relationship: __________ Ph: __________

If we are unable to contact you by phone, do we have your permission to leave a message with a family member?

Yes/No

Do you consent to receive SMS reminders of your appointments with the practice? Yes / No

Medicare No: __________ Ref No: _____ (this is the number next to your name)

Pension Card: __________ DVA card: Number: __________

Private Health Fund: __________ Member No: __________

Referring Doctor: __________ Usual GP : __________

Do you have any allergies? Yes / No If so, what? __________

MEDICAL HISTORY

Do you have a past medical history of any of the following? (please tick)

- ☐ Hypertension (High blood pressure)
- ☐ Hypercholesterolaemia (high cholesterol)
- ☐ Diabetes
- ☐ Stroke
- ☐ Family history of vascular disease
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Kidney Disease
- ☐ DVT

SOCIAL HISTORY

Smoking (Please circle): Never smoked Ex-smoker Still smoking How many? _____

Please turn the page and read and sign the consent

CONSENT TO COLLECT PATIENT INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We requires 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 specialist outside this medical practice as advised by you.
   - I understand the reason why my information must be collected.
   - I understand that I am not obliged to provide any information requested 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 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 purpose other than the above, my consent will be sought.
   - I consent to the handling of my information by this practice for the purpose set out above, subject to any limitations on access or disclosure of which I may notify this practice.
4. I consent to clinical photographs to be taken for the purpose of monitoring, comparison and education purposes to aim my treatment.
5. I consent to receive SMS reminders of my appointments in the practice.

______________________________ ____

Patient name (Please print) Signature