MR DAVID LLOYD - COLORECTAL SURGEON AND COLONOSCOPIST

NEW PATIENT DETAILS:

To protect privacy when giving information we request that you complete this form.
If you have any difficulty, the office staff will be only too happy to assist.

(Mr / Mrs/ Miss/ Mst/ Ms / Dr)

First Name: _____

Surname: _____

Date of Birth: _____ **Occupation:** _____

Residential Address: _____

_____

Postal Address (if different to above): _____

Home Telephone: _____ **Work:** _____

Mobile: _____ **Email:** _____

Name & Address of Person Responsible for Account (parent/guardian/workers compensation etc.)
if different to above

_____

_____

Aged Pension: **(Yes / No) please circle**

Dept. Veterans Affairs: (Yes / No) please circle **DVA NUMBER:** _____

Medicare Number (10 digits): _____

Number beside your name: _____ **Expiry date:** _____/_____

Private Hospital Insurance: (Yes / No) please circle (Extras Cover does not apply)

Private Fund Name: _____ **Membership No.** _____

Referring Doctor: _____ **General Practitioner:** _____

IN THE EVENT AN APPOINTMENT / HOSPITAL BOOKING NEEDS TO BE CHANGED AND STAFF ARE UNABLE TO CONTACT YOU DIRECTLY, PLEASE NOMINATE A PERSON AND PHONE NUMBER TO ENABLE STAFF TO LEAVE A MESSAGE.

Name: _____ **Contact No:** _____

What relationship is this contact person to you?: _____

MEDICAL HISTORY FORM

Please complete all of the following questions to assist Mr Lloyd with the treatment of your condition. The contents of this form will be strictly confidential.

Your name: _____

Have you ever had any of the following: (please tick)

	Yes	No
Anaemia / Blood diseases	( )	( )
High Blood Pressure	( )	( )
Blood clots in lungs/legs	( )	( )
Bleeding tendencies	( )	( )
Blood transfusion (if so, when)	( )	( )
Rheumatic fever	( )	( )
Heart Attack	( )	( )
Chest pain / Angina	( )	( )
Indigestion / Heartburn	( )	( )
Neurological disease / Stroke	( )	( )
Psychiatric disease	( )	( )
Epilepsy / Fit	( )	( )
Hepatitis / Jaundice	( )	( )
Diabetes	( )	( )
Bronchitis / Pneumonia / Emphysema	( )	( )
Asthma	( )	( )
Tuberculosis	( )	( )
Kidney or Urinary disease	( )	( )
Cortisone or Prednisolone treatment	( )	( )
Tropical illness	( )	( )
Any inherited diseases (please specify)	( )	( )

_____

Do you consider yourself at risk for:
HIV / Hep B / Hep C **Yes / No**

Weight:_____ **Height:** _____

Your Blood Group (if known) _____

Alcohol consumption **Yes / No**

If yes, number of standard drinks per week _____

Smoking habits **Yes / No**

If yes, amount per day _____

Have you smoked previously? **Yes / No**

If yes, when did you quit? _____

Allergies:
List below any known allergies

_____

_____

_____

Medications:
Name Strength How often

_____

_____

_____

_____

_____

_____

_____

_____

Relevant Family History:

_____

_____

_____

Past Operations & General Anaesthetics:

_____

_____

_____

MR DAVID LLOYD - PRIVACY STATEMENT - 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 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 pro-active 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 hospitals, 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 referral.**
- **Disclosure for research and quality assurance activities to improve individual health care and practice management.**

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 obliged to provide any information requested of 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.

Signed: _____

Name: _____

Date: _____