The Surgical Precinct

Patient Registration, Financial & Privacy Act Consent

Dr Christine Lai
Dr David Walsh
Dr Leong Tiong

Title Mr / Mrs / Miss / Ms / Dr / Other

First Name

Surname

Middle Name

Address 1

Address 2

Suburb **State** **Postcode**

Date of Birth / /

Phone ☐ Home ☐ Business ☐ Mobile

Email

Occupation

Account Type Private / DVA / Workcover

Account Holder Name (if patient <18yo)

Medicare № **Ref** **Expiry Date** / /

Health Fund (Hospital Cover) **Membership №**

DVA № (if applicable) **DVA Colour** White / Gold / Orange

HCC Pension № **Expiry Date** / /

Referring Doctor

GP Name & Address (if different to referring doctor)

Marital Status

Next of Kin **NOK Phone**

Relationship of Next of Kin To You

PATIENTS PRESENTING WITH A BREAST PROBLEM PLEASE COMPLETE THE REVERSE PAGE

Financial Consent

All patients are required to pay the consultation fee on the day of consultation as explained in the *Practice Information For Patients Brochure*.

I acknowledge the fees displayed at the practice, and agree to the payment terms.

Privacy Consent

In order to provide healthcare to you, it is necessary for the doctors and staff to collect personal information about yourself, your medical history and also your family's medical history. This information may be disclosed to other 3rd parties involved in treating you.

Our Privacy Policy is available in our waiting rooms and also on our website should you wish to understand more about how we collect and disclose health information.

I give consent for the collection, use and disclosure of health information (as per the practice Privacy Policy).

Information pertaining to how the practice handles *The Results of Tests* and *Explanation of fees* are in the *Practice Information For Patients Brochure*. Please take the time to read this information and ask staff if you have any questions.

Signed **Signed**

Print Name **Print Name**

Date **Date**

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Please answer the following questions if you are being seen for a breast condition / problem.

Name

Last menstrual period start date (if applicable) / /

History of number pregnancies and childbirths (if applicable)

Age at first pregnancy / /

Current/previous use of the Pill or HRT (for how many years)

Please provide as much information when answering the following questions

Any previous history of breast biopsies and results if known	☐ Yes	☐ No
Any previous personal history of breast cancer	☐ Yes	☐ No
Previous personal history & treatment of lymphoma with mantle radiotherapy	☐ Yes	☐ No

Do you have any family members diagnosed with the following

Breast Cancer	☐ Yes	☐ No
Ovarian Cancer	☐ Yes	☐ No
Soft tissue tumours or sarcomas	☐ Yes	☐ No
Colorectal Cancer	☐ Yes	☐ No
Other Cancer	☐ Yes	☐ No

If you answered yes to **any** question, please state the type of cancer, the relative's relationship to you & their age at diagnosis below.
(e.g. maternal aunt aged 53)