PERTH UROLOGY CLINIC

Hollywood:

Suite 15 / Ground
Hollywood Medical Centre
85 Monash Avenue
Ned lands WA 6009

p:(08) 9322 2435
f: (08) 9322 5358

Wexford:

Suite 23 / Level 1
Wexford Medical Centre
3 Barry Marshall Parade
Murdoch WA 6150

p:(08) 6189 2970
f: (08) 6225 2105

New Patient Questionnaire - Welcome to our practice
Patient or guardian to complete

Todays Date _________

Your Details

Surname First Name Gender DOB

Residential Address Suburb Postcode

Occupation/ How you spend your time

Home Phone Work Phone Mobile Phone

What number can we call you on regarding results/recalls or change to an appointment?

Email

Please complete the following

Is English your first language? **Yes** / **No**

If no, please indicate if an interpreter is required: **Yes** / **No**
Please indicate language:

Aboriginal/Torres Straight Islander? **Yes** / **No**

Please state other cultural background:

Would you like to be contacted via SMS (mobile text message) for appointment reminders, recall reminders or messages: **Yes** / **No**

Do you consent to Perth Urology Clinic sending you information (such as details of procedures/appointments) (not spam) via email: **Yes** / **No**

Can we leave messages for you identifying the surgery as the caller? **Yes** / **No**

Health Fund Details

Health Fund | Membership Number

Inpatient Private Hospital Cover - **Y** / **N**

Medicare Number | Ref Number | Expiry Date

DVA Number | Card Color | Expiry Date

Is your consult part of a worker's compensation claim/motor vehicle accident: - **Y** / **N**
If so:

Date of Accident | Claim Number

Insurance Company Name/Address:

Your GPs Details

GPs Name | Practice | Suburb

Referring Doctors Details (if different to above)

Doctors Name | Practice | Provider Number

Next of Kin/Emergency Contact

Name | Relationship

Address (if different to your own) | Suburb | Postcode

Contact Number

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I authorize the following person to take messages regarding a recall, reminder or change of appointment:

Name ______________________ Relationship ______________________

____

Contact Number ______________________

Help Us To Help You

How did you hear about Perth Urology Clinic? We are interested to know!

GP
Word of Mouth
Web Search (Google)
Social Media (Facebook, Twitter)
Other _

Is there anything that you would like to tell us that may help us improve our patient care?
(If you don't feel comfortable writing it down, please mention your concerns to your doctor or one of our staff)

NAME: ______________________

DATE OF BIRTH: ______________________

ADDRESS: ______________________________________

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Health Questionnaire

Do you *or have your ever* had:

Diabetes	Y / N
High Blood Pressure	Y / N
Heart Problems	Y / N
Breathing Problems	Y / N
Kidney Problems	Y / N
Thyroid Disease	Y / N
Stroke or Similar Problems	Y / N
Epilepsy, Seizure or Fits	Y / N
Parkinsons Disease or Multiple Sclerosis	Y / N
Spinal Problems	Y / N
Tendency to Bleed	Y / N
Tendency to Clot (Deep Vein Thrombosis, PE)	Y / N
Depression or other psychiatric illness	Y / N
Chemotherapy or Radiation Therapy	Y / N
HIV or Hepatitis	Y / N
Problems with Anaesthetics	Y / N

Any other medical problems?____________________________________

____

What previous surgery have you had? (please list)

Please List all allergies (including food allergies)

What medications do you take (including vitamins and supplements)?
Please note the dose and time that you take them.
Please note if on any blood thinners (warfarin, clopidogrel, aspirin)

____

____

____

____

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Privacy Policy

We value the doctor/patient relationship. Privacy is vital to such a relationship. *Perth Urology Clinic* is committed to protecting the privacy of patient information in a responsible manner. The Privacy Act 1988 and its recent amendments formalize the already existing and acknowledged privacy obligations of our practice.

Our doctors and staff collect information from patient primarily to provide proper care and treatment. We have a legal and ethical duty to protect patient information. Patient information may have to be disclosed to other doctors, nurses, therapists and medical technicians so that proper health care is not compromised.

The doctors in this practice are members of various medical and professional bodies including medical defence organisations. These organisations provide valuable services to their members. They require members to provide information in relation to their medical practice, which may include patient information. Our medical defence organisation is Avant Insurance. If you wish to know whether your health information is held by this organisation you may write to Avant Insurance, Level 1, 91 Havelock Street, West Perth WA 6005.

Our Privacy Policy explains how we collect, use and disclose your personal information, how you may access that information and how you may seek the correction of any information. It also explains how you may make a complaint about breach of privacy legislation. If you wish to view our Privacy Policy, please ask our receptionist for a copy.

You can assist in maintaining the accuracy of your information by advising the practice of changes to your personal contact details.

I have read the above privacy information. (please sign and date below).

Name ________________________

Date of Birth ________________

Address ____

Signature _______________________

Date ______________________

Thanks,
and welcome to Perth Urology Clinic

Form 22- 7/6/19