BREAST & SURGICAL
ONCOLOGY
at The Poche Centre

40 Rocklands Road
North Sydney NSW 2060
Tel: 02 9911 7250
Fax: 02 9954 9938

Patient Information Sheet

Mr/Mrs/Ms/Miss/Dr

_____ _____

Title (Circle one) **First Name** **Middle Name** **Surname**

Preferred Name _____ **Date of birth** _____

Address: _____

Home Phone _____ **Mobile** _____ **Work** _____

Occupation: _____ **Email:** _____

Medicare No _____ **Patient Ref No.** _____ **Expiry** _____

Private Health Fund _____ **Membership No.** _____ **Ref** _____

Pension/DVA Card No _____ **Expiry** _____ **Type (circle) Aged/Health Care/Disability/Other**

Name of next of kin _____ **Relationship** _____ **Tel No** _____

GP Practice Name and Address _____

_____ **GP Tel No.** _____

Please add other doctors (apart from your GP) requiring copy of correspondence

_____

PATIENT CONSENT FOR COLLECTION, USE AND DISCLOSURE OF INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We require 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 specialists outside this medical practice as advised by you.
4. De-identified information for quality assurance and research activities of the unit.

I have read and understood the Privacy Policy of BSOPC in relation to the collection, use and disclosure of my personal information.

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

I understand that I am entitled to access my own health records except where access would be denied as per the Privacy Act.

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 purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

I consent to my de-identified data being collected for breast cancer or melanoma research database.

I consent for my de-identified clinical photos to be used in teaching presentations.

Signed _____ **Date:** _____

Patient Name (Please print) _____