Drummond House

BALLARAT

414 Drummond Street North, Ballarat Central VIC 3350
P 03 5334 3233 F 03 7048 9070 E reception@dhballarat.com.au www.drummondhouseballarat.com.au

Patient Registration Form

(Please complete all fields & return this form to the practice with your referral prior to your appointment).

Contact Details

Date of appointment:

Title | Surname

Given Names

Date of birth

Residential Address

City | State | Postcode

Postal Address

City | State | Postcode

Phone (Home) | Phone (Business) | Mobile

Email

Memberships

Medicare no. | Ref no. *(Number in front of your name)* | Expiry

Private Health Insurance? ☐ Y ☐ N

Name of Health Fund | Member no.

Have you served your waiting period on your Health Fund? ☐ Y ☐ N Do you have an excess to pay on your Health Fund? ☐ Y ☐ N

Pension no. *(Blue pension card only - NOT healthcare card)* | Expiry

Dept Veteran's Affairs ☐ Gold ☐ White | Card no.

Workcare or TAC no. *(Please bring relevant paperwork).*

Medical Information

Name of Referring Doctor

Name of General Practitioner

Name of Emergency Contact

Relationship | Phone

Medical Information

Height *(cm or feet & inches)* _____ Weight *(kg/stones)* _____

Are you taking any blood thinning medication? ☐ Y ☐ N

If yes, please name your blood thinning medications: _____

_____

Are you diabetic? ☐ Y ☐ N If yes, is your diabetes controlled by medication/insulin? ☐ Y ☐ N

If yes, please name your diabetic medications: _____

_____

Have you ever had a mammogram, breast ultrasound or breast MRI before? ☐ Y ☐ N

If yes, please give location, type & date of most recent breast imaging: _____

_____

Have you ever had a breast biopsy before? ☐ Y ☐ N

If yes, please give location & date of biopsy: _____

_____

Please list any other medications you take:

Medication:	Reason for taking:

Do you have any allergies? ☐ Y ☐ N

If yes please list your allergies:

Allergy:	Type of reaction:

Are there any other medical alerts or aspects of your health you would like us to know? _____

Privacy Policy

Your privacy is very important to us. This privacy policy provides information about the personal information we collect, and the ways in which we use that personal 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 a full medical history so that we may properly assess, diagnose, treat and be proactive 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 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 referrals.
- Details of your name, address and phone number may be passed onto debt collection agencies if necessary to recover outstanding dues.

On occasions the practice undertakes training of students, or research activities. In these instances, disclosure of your information to other doctors at the practice, locums and registrars attached to the practice may occur for the purpose of patient care and teaching. Please let us know if you do not want your records accessed for these purposes, and we will note your record accordingly.

As part of this practice's commitment to improve the quality of care, the practice audits the treatment and outcomes of the care delivered to its patients. This usually involves all components of care for a particular disease, including that by other practitioners and institutions. When required, care plans are discussed with other doctors and health care professionals in a multidisciplinary meeting to ensure a coordinated approach. If you do not wish your care to be audited or discussed at multidisciplinary meetings please advise your doctor.

Disclosure of information for research and quality assurance activities may occur to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to "opt out" of any involvement.

All reasonable technical and organisational precautions will be taken to prevent the loss, misuse or alteration of your personal information. All personal information you provide will be stored securely. Information relating to electronic transactions will be protected by encryption technology.

- 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 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 am aware of my right to access the information collected 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 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.
- I consent to the collection of my information from medical imaging, pathology, medical records from the hospitals, and other people who have been involved in my medical care.
- I consent to the collection of medical photographs to be stored in my medical record for monitoring and treatment planning. These photographs will be exclusively used for educational, research, and informational purposes within the medical practice. They will not be utilised for any commercial, promotional, or other non-educational purposes without my explicit written consent.

By signing below, I affirm that I have read and understood the contents of this Privacy Policy and agree to the terms and conditions stated above:

Today's Date:

Full Name

Signature

If you have any questions about this privacy policy, please contact us:

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Drummond House
BREAST SURGERY

Dr Emma Gannan
BBioMedSci (Hons) MBBS (Hons) DipAnat MS (BreastSurg) FRACS
SPECIALIST BREAST SURGEON