

PATIENT INFORMATION SHEET

(Please print clearly)

Title: (Please circle) Mr Mrs Miss Ms Dr

Surname: Given Names:

Address: Post Code:

Postal Address: (if different from above)..... Post Code:

Telephone: Home: Work: Mobile:

Date of Birth:/...../..... Occupation:

Next of kin/contact person: Contact No:.....

Relationship to person (e.g. mother, husband, friend):

Medicare No: _ _ _ _ _ _ _ _ _ _ Ref No/number on card: Exp:/.....

Or

DVA YES / NO

FILE NO:

Health Fund: Membership No:

Pension / Health Card No: Exp:/...../.....

GP's Name and Address: (if different from referring doctor)

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If you are a male patient and have one of the following symptoms, please request a Urinary Symptom Assessment Form from the reception desk.

- Urinary frequency
- Urgency or
- Reduced urine stream etc

To comply with the Privacy Act 2001, all patients need to provide consent for the following important aspects of their medical care:

- I agree that Dr Nagaonkar takes a full medical history that relates to my medical condition and management.
- I agree that relevant information may be obtained from other medical practitioners, such as GPs and Specialists, other health care providers, pathologists, hospital and day surgery units as necessary.
- I agree that Dr Nagaonkar may discuss my medical history diagnosis and management with my general practitioner and other relevant medical specialists in relation to medical management.
- I understand that I may apply to access my health records.
- I agree that Dr Nagaonkar keeps a data base and that this information may be used in an anonymous fashion for research purposes.
- I agree that Dr Nagaonkar collects relevant information (e.g. X-rays) in digital format to monitor my progress and/or for research purposes.

Depending on your symptoms and clinical requirements, Dr Nagaonkar may have to perform additional tests. This will incur an additional non invasive procedure charge (Medicare rebate available). Please indicate according –

I do / do not wish to undergo necessary additional non-invasive procedure/s.

Patient's Signature:

Date:/...../.....