Dr Marc Paffen
MD, Med Spec (uroL, NL)
FEBU, FRACS (urol)
Urologist

1130 Padman Drive
West Albury NSW 2640
Phone: 02 6021 5620
Provider No: 485278FT
ABN: 348 8664 0747
LSPN: 9500

New Patient Information

Mr/Mrs/Ms/Miss/Other_____
Title (Circle one) **First Name** **Surname**

Address:
_____**Home Phone**_____

Suburb_____ **Work Phone**_____

State_____**Postcode**_____ **Mobile**_____

Date of birth_____ **Occupation** _____ **Marital Status** _____

Medicare No._____ **Reference on card**_____

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

Health Care/Pension/DVA Card Number_____ **Type(circle)** Aged Pension/DVA/Other

Email _____

Next of Kin: Name_____ **Phone:** _____

Referring Doctor_____ Specialist/GP referral (circle one)

Usual GP (if different from above)_____**Usual GP Phone No**_____

Please list your current medications, prescription and non prescription:

Medication name, dose and frequency	Medication name, dose and frequency

Do you have any allergies? Please list;
_____
Do you have any medical conditions or significant past medical history? (Eg. heart condition, stroke, kidney disease, hypertension, etc). Please list;
_____

_____
Have you had any previous surgeries or procedures? Please list;

Operation/Procedure, year	Operation/Procedure, year

CONSENT TO COLLECT PATIENT 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.

- I understand the reasons why my information must be collected.
- 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 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 this practice obtaining medical information from other health professionals/organisations pertaining to my medical planning and treatment.

_____

Patient's Name (Please print)

_____

Signature Date