Waverley Breast Care

Waverley Private - Specialist Health Centre
343-357 Blackburn Road
Mount Waverley VIC 3149
T:(03) 9116 4770
F:(03) 9116 4777
E: admin@waverleybreastcare.com.au

Patient Details

Title: Other

First name

Last name

Preferred name

Date of birth

Gender: Select

Pronouns: Select

Occupation

Aboriginal/Torres Strait Islander: N/A

Address

Suburb

Postcode

VIC

Phone number

Email

Do you consent to receiving recall and reminder messages via SMS? Yes

Do you consent to correspondence being uploaded to MyHealthRecord? Yes

Emergency Contact

First name

Last name

Relationship to patient

Phone number

Medicare number

Ref

Expiry: 03/25

Do you have Private Health Insurance? **Yes** **No**

Do you have a Healthcare, Pension or DVA Card? **Yes** **No**

General Practitioner Details

Name

Address

Suburb

Postcode

VIC

Waverley Breast Care

Medical History

Smoking Current smoker

Diabetes No

Family history of cancer **Yes** **No**

Medical Problems

Past Operations

e.g. Appendicectomy 2003

Medications

Allergies **Yes** **No**

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Personal Health Information Consent

Privacy Patient Information

To provide a high standard of medical care we need to collect personal information from our patients. This information is usually collected from the patient but may be collected from family members and other health care providers with the patient's consent. At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your personal health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your Doctor. If you require another member of your family to access your medical results of tests, this cannot be done without a consent form signed by the patient. Please ask our reception staff for this form if you require one. Thank You

Consent

I provide my consent for Waverley Breast Care to collect, use and disclose my personal information as outlined above. I provide consent for referrals and results to be sent to a medical specialist or doctor by facsimile. I provide consent for messages to be left with immediate family members / defacto partner (e.g. appointment confirmation). I understand that I am entitled to access my own health records except where access would be denied as outlined above. I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

Signed by patient

Patient's name

Date

Signature of Parent or Guardian (if applicable)

Name of Parent or Guardian