Suite 406, San Clinic
185 Fox Valley Road
Wahroonga NSW 2076
Tel: 9052 7586 Fax: 9053 6719
Email: drwines@urologist.net.au

ACQUAINTANCE SHEET – DR MICHAEL WINES

PERSONAL INFORMATION

Mr □ Mrs □ Ms □ Miss □ Dr □ Married □ Single □ Divorced □ Widowed □ De-Facto □

Surname ____

Given Name ____

Address ____

Suburb ____ Postcode ___________

Contact Numbers (H)______________________ (M) ___________________________

Email address __________________________ Date of Birth ______________________

Medicare Number _________________ Your Place on Card _______ Expiry Date _________

Veterans Affairs Number ____________ Gold □ White □

Are you in a Private Health Fund Yes □ No □

Name of Fund _______________________ Membership Number __________________

Country of Birth ____________________Language Spoken at Home ________________

Occupation ____

Next of Kin ___________________________ Relationship to You _________________

Contact Numbers (H) _____________________ (M) ___________________________

Name & Address of GP ____

Name of Referring doctor if different from GP____________________________________

MEDICAL INFORMATION Please tick the appropriate boxes:-

Present Medications ____

____

Drug Allergies ____

Do you have a Latex Allergy Yes □ No □ Do you have a Betadine/Iodine Allergy Yes □ No □

Previous Surgeries ____

Have you had any previous issues with anaesthetics Yes □ No □

If yes, please specify ____

Are you a smoker Yes □ No □ How long have you been a smoker _______________

How many cigarettes per day _____

Do you drink alcohol regularly Yes □ No □

Surname ____________________________ **Given Name** ________________________

CONSENT FORM

Our Privacy Policy at March 2014 outlines Dr Michael Wines' information handling practices, including the way we collect and use your information and how you can access your information.

If you have any questions in relation to this consent form or our Privacy Policy please ask one of our staff who would be only more than happy to assist.

Please provide your consent to our collection and use of your health information by signing and dating this form where indicated.

Please Circle –

I do/do not consent to Dr Michael Wines and his staff using my health information to manage my condition, treatment and/or diagnosis.

I do/do not consent to being contacted by Dr Michael Wines or his staff with the possibility in participating in future research.

I do/do not consent to de-identified (anonymous) information/images/videos from my medical file being used for education or research purposes and/or for publication to further medical knowledge in this treatment area.

……………………………………………………………………………………………………….
Signature of Patient

……………………………………………………………………………………………………….
Signature of Witness

………………………………………………………… ……………………………………
Name of Witness Date Witnessed