Sydney Urological Associates

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

ACQUAINTANCE SHEET – PROF HENRY WOO

PERSONAL INFORMATION

Please tick the appropriate boxes:-

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

Surname _____

Given Name _____ Male □ Female □

Address _____

Suburb _____ Postcode _____

Contact Numbers (H)_____ (M) _____

Email address _____

Date of Birth _____ 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_____

Surname _____

Given Name _____

MEDICAL INFORMATION

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 _____

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 □

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 Prof Henry Woo's 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/don't consent to Prof Henry Woo and his staff using my health information to manage my condition, treatment and/or diagnosis

I do/don't consent to being contacted by Prof Henry Woo or his staff with the possibility in participating in future research

I do/don't 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