Dr Ruth Collins
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ACQUAINTANCE SHEET - DR RUTH COLLINS
PERSONAL INFORMATION

Mr ☐ Mrs ☐ Ms ☐ Dr ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ De-Facto ☐

Surname ……………………………………………………………………………………………………..

Given Name _……………………………………………………………………………………………

Address ……………………………………………………………………………………………

Suburb ………………………………………………………………… Post Code ………………………………

Contact Numbers (H) ………………………………… (M) ……………………………………………………

Can we contact you via Mobile SMS Text messaging? Yes ☐ No ☐

Email Address. ……………………………………………………….. Date of Birth ………………………………

Medicare Number ……………………………………….. Your Place on Card ………. Expiry Date ………

Veterans Affairs Number …………………… Gold ☐ White ☐ Pension Card Number ……………………

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 and Address of GP …………………………………………………………………………………………

Name of Referring Doctor if different from GP ……………………………………………………………

MEDICAL INFORMATION

Current Medications (please note your GP referral letter usually lists all the medications you have ever been prescribed and is often not an accurate list of what you are taking at present)

………………………………………………………………………………………………………

………………………………………………………………………………………………………

Drug Allergies ……………………………………………………………………………………

Do you have a Latex Allergy? Yes ☐ No ☐ Do you have an allergy to Iodine/radiology dye Yes ☐ No ☐

Previous Operations/procedures ………………………………………………………………...

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Have you had any previous issues with anaesthetics? ………………………………………….

If yes, please specify ……………………………………………………………………………

Are you a smoker? Yes ☐ No ☐ How long have you been a smoker?

How many cigarettes do you smoke a day? ………………………………………………..……..

Do you drink Alcohol regularly? Yes ☐ No ☐

Surname ……………………………….. Given Name ……………..…………………

Consent form

Our Privacy Policy from March 2014 outlines Dr Ruth Collins' 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 will be happy to assist your enquiry.

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 Ruth Collins and her staff using my health information to manage my condition, treatment and diagnosis

I do/do not consent to being contacted by Dr Ruth Collins or her staff with the possibility of participating in future research

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

……………………….	………………………..	………………………..
Signature of patient	Signature of witness	Name of witness

Date ……………………