

DR DAVID JEFFERSON

MBBS (SYD) FRACS (Urol)

UROLOGICAL SURGEON



Title: Mr / Mrs / Miss / Ms / Dr

First Name: _____ Surname: _____

Address: _____ Postcode: _____

Date of Birth: _____ Age: _____ Occupation: _____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Email Address: _____

Referring Doctor: _____

GP Name (if not Referring Doctor): _____

Medicare No: _____

Position on Medicare Card (the number in front of your name) _____

Expiry date on Medicare Card: _____

Private Health Fund: YES / NO

Top Cover

Basic Cover

Extra Cover Only

Fund Name: _____ Membership No: _____

Age Pension No (if applicable): _____ Expires: _____ Type: Age Disability

Department of Veterans Affairs No: _____ Type: Gold White

Next of Kin (name): _____

Relationship: _____ Phone No: _____

Regular Medications (including Aspirin): _____

Allergies: _____

Medical Conditions (e.g. Diabetes, Heart Disease): _____

Previous Surgery: _____

Privacy statement:

As a patient of Dr David Jefferson, a medical record containing personal information will be maintained throughout your treatment. These records will contain information including, but not exclusive to, your name, address, date of birth, Medicare number and your referring doctor's details. During the period of assessment and ongoing management, information of relevance is recorded in clinical notes. These records are stored securely and may be kept for up to seven years following your last consultation. If necessary, for the continuity of your medical care, this information may be shared with other health practitioners involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information. A fully copy of our privacy policy is available from reception. By signing this document, you are indicating that you have understood and agree with the conditions of our privacy policy.

Signed: _____ Date: _____