Dr Caroline Dowling
UROLOGIST

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Title:	First Name:	Surname:
Address:		
Suburb:		Postcode:
Date of Birth:	Email:	
Contact Number: **(H)**	**(W)**	**(M)**
Medicare Number:		Reference Number: (Number next to your name)
Next of Kin Name:		Contact Number:
Relationship to you:		
Private Health Insurance: ☐ Yes ☐ No		
Private Health Insurer:		Membership Number:
Pension/Concession Number:		Expiry Date:
DVA Number:		☐ Gold ☐ White
Are you Diabetic? ☐ Yes ☐ No		**If answered yes, please specify type:**
Do you take blood thinners? ☐ Yes ☐ No		**If answered yes, please list below:**
1. ______	2. ______	3. ______
Do you have any allergies to medications? ☐ Yes ☐ No		**If answered yes, please list below:**
1. ______	2. ______	3. ______
List Medications (if more than three **prescription** medications please turn over)		
1. ______	2. ______	3. ______

Fee Policy: All consultation fees are due and payable on the day of consultation. The practice does not routinely bulk bill patients. Procedures are in addition to the consultation; please refer to fee schedule for costs. The costs for any surgical procedures will be discussed, if necessary, with you during consultation. DVA, TAC and Workcover are also charged at different rates. Failure to attend a booked appointment, without prior notification, will incur a fee. By signing this form you are agreeing to the practice fee policy.

Privacy Statement: This practice handles personal information in accordance with the Victorian Health Records Act and the Commonwealth Privacy Act. I consent to the handling of my information by this practice for the purpose of providing quality health care, associated administrative and billing purposes. I give permission for medical information to be obtained from any other source in order to help with my treatment. I also give permission for medical photography to be used for planning procedures and follow up. Use for teaching, audit research or publication would require additional consent to be obtained. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

I have read the above fee policy and privacy statement. I consent to the taking and use of my medical records as described. I have viewed the fees and agree to pay the costs of consultations and any surgical procedures performed.

Signature:	Date: