Patient Registration

Please circle: Dr / Mr / Mrs / Ms / Miss / Master/ _____ Surname: _____

First name: _____ Middle name:_____

Prefer to be known as: _____ Maiden name*: _____
(*only if still used for your Medicare card)

DOB: _____/_____/_____ Age: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Postal address (if different to above): _____

Suburb: _____ State: _____ Postcode: _____

Phone Home: _____ Work: _____ Mobile: _____

Email: _____
Please note, the use of emails is not secure and will therefore only be used as an emergency contact

☐ I would like to receive notice of special offers via email (not often).

Occupation: _____

Medicare #: _____ _____ Reference # _____ Expiry date: _____ /_____ /_____
(# next to your name)

Are you privately insured: Yes / No (Relevant only for inpatient surgeries only, not for consultations)

DVA Card Number: _____ *Gold* / *White** *Description: _____
(Dpt. of Veterans Affairs)

Emergency Contact Information

Emergency Contact Person Name: _____ **yes / no***

Emergency Contact Number: _____ Relationship: _____

DO YOU GIVE CONSENT FOR ANY OF THESE CONTACTS, ABOVE OR BELOW, TO ACCESS YOUR MEDICAL RECORDS (ACCESS RESULTS, DISCUSS YOUR CARE ETC.? **(CIRCLE YES OR NO)

Alternate contacts:

Name: _____ Phone: _____ Relationship:_____ **yes / no***

Name: _____ Phone: _____ Relationship:_____ **yes / no***

Please continue over page…

Allergies

Do you have any allergies (including medications): No / Yes

Allergy to: _____ Reaction: _____

_____ _____

_____ _____

Health Consents

It is a requirement of our practice that the below consent forms are read and agreed to in order to see the Dermatologist

Services Performed

During your initial and follow up consultations, the Dermatologist may recommend treatment(s) to be carried out on the same day. Services and treatments (e.g. biopsies, injections) carried out may incur further costs on top of the consultation fee. If you do not wish to proceed with these treatments, please inform your dermatologist prior to these treatments being carried out.

☐ **I have read and understood the above information. I am aware that services and / or treatments performed during my consultations may incur fees on top of the consultation fee.**

Health Information Collection and Use Consent Form

We require your consent to collect and use the information on this form for the following reasons:

- Administrative purposes
- Accurately assess your medical condition and provide treatment
- Billing purposes within our practice and with Medicare
- Correspondence with other Doctors and medical/pathology practices
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.

☐ **I have read and understood the above information and agree that my information must be collected for the mentioned purposes.**

Patient Signature:_____ Date: _____/_____/_____

OR Parent/Guardian Signature: _____ Date: _____/_____/_____

Parent/Guardian Name: _____ Relationship: _____