PATIENT REGISTRATION FORM

SYDNEY dermatology group

To maintain your medical records, it is necessary to have the following information which will be handled confidentially. Please fill in this form completely and present your Medicare, Pension and/ or Veteran Affairs card to reception staff.

PERSONAL DETAILS

TITLE : ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Other .....

NAME & D O B : Surname | Given names | Date of birth _ _ /_ _ /_ _ _ _

MEDICARE NO. : _ _ _ _ _ _ _ _ _ _ _ | Number next to name _ | Valid to _ _ /_ _ _ _

HOME ADDRESS :

POSTAL ADDRESS : (if different from home address)

TELEPHONE : home | work | Mobile

OCCUPATION :

EMAIL :

PENSION NO. : (if applicable) CRN | Expiry date _ _ /_ _ /_ _ _ _

VETERAN AFFAIRS NO. : (if applicable) ☐ Gold ☐ White

MEDICAL INFORMATION

Are you taking medications ? ☐ yes ☐ no If yes, list . . . . . .

Are you taking Aspirin or Warfarin or blood thinners ? ☐ yes ☐ no If yes, list . . . . . .

Are you allergic to any medications ? ☐ yes ☐ no If yes, list . . . . . .

PRIVACY NOTE

I agree to allow the doctors and staff at this practice to access all the relevant information regarding my medical conditions. I agree that the doctors and staff maybe required to forward/obtain information about my medical condition/history from my referring doctor or other health care providers. I understand that my clinical records may be accessed or reviewed by staff at this practice.

FEES

This is a private practice and we do not bulk bill. The fees charged by this practice are generally lower than those recommended by the Australian Medical Association and are payable at the time of consultation. The following payment methods are available: cash, cheque, EFTPOS (Visa, Mastercard & debit cards). Payment is required at time of consultation.

I declare that, to the best of my knowledge, the information I have provided in the form is accurate.

SIGNED : Signature | Date

If signed by parent / guardian, please complete: Parent/guardian name - print | Contact no.