SYDNEY SKIN

CONFIDENTIAL PATIENT INFORMATION

PERSONAL DETAILS

Title:_____ Given Name: _____ Surname: _____

Date of Birth: _____ Male/Female: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Phone Home: _____ Work: _____ Mobile: _____

Email Address: _____

Next of Kin (Emergency Contact)

Name: _____ Relationship: _____ Contact No.: _____

Referring Doctor: _____

Address: _____

Name of **LOCAL** Doctor (Your GP): _____

Address: _____

Medicare No: _____ **Ref No:** _____ **Exp Date:** _____

Age/Disability Pension No.: _____ Exp Date: _____

DVA Card No.: _____ Colour of Card: _____ Exp Date: _____

Private Health Fund: _____ Member No.: _____

Current Medications: _____

Are you allergic to any medications? _____

FOR MEDICARE CLAIMS

Parent/Guardian (If patient is a child <18 years):

Title:_____ Given Name: _____ Surname: _____ DOB: _____

Medicare Card No.: _____ Ref No.: _____ Exp Date: _____

PRIVACY INFORMATION

I give permission to contact other health care providers as necessary regarding my case via phone, post or email, in order to discuss the case, obtain information or request opinions. ☐ Y ☐ N
Please note all images used will be de-identified.

I give permission for my clinical photographs to be used for medical education. ☐ Y ☐ N

I give permission for my clinical photographs to be used for patient education. ☐ Y ☐ N

Please note: There will be ADDITIONAL CHARGES for any treatment or procedure during the consultation if required (eg. skin biopsy, skin prick testing etc.)

If a skin biopsy or an excision is performed, the tissue sample will be sent for pathology. The pathologist will bill you for this. Medicare rebates apply.

Please note that a patient privacy policy document is available.

By providing your signature below you will indicate that you understand the terms outlined above.

Signature: _____ Date: _____