hope DERMATOLOGY

Patient Registration Form - Website
230 York St, South Melbourne VIC 3205
T: 9039 5644 F: 9686 9898
www.hopedermatology.com.au

Title: Mr/Mrs/Ms/Miss/Mst/Dr/Prof (circle) **First Name:** _____

Surname: _____ **Known As:** _____

Address: _____

Suburb: _____ **Postcode:** _____

Postal address (if different from above): _____

Date of birth: _____ / _____ / _____ **Occupation:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile:** _____

Email Address: _____

Medicare No.: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Reference No.** _____ **Expiry:** _____ / _____

Pension Card: _____ **Expiry:** _____ / _____

DVA Card No.: _____ **Gold Card Yes/No (pls circle)** **Expiry:** _____ / _____

If patient under 18 or not responsible for account: Details are required for Medicare purposes

Parent's Name: _____ **Parent's DOB** _____ **Contact No.:**_____

Parent's Medicare Card No.: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Ref No.** ____ **Expiry:** ___ / ___

Next of Kin (or carer): _____ **Contact No.:** _____

Usual GP (if different to referring doctor): _____

Privacy consent

Federal Privacy Law requires your consent in order for Hope Dermatology to collect your personal information. Your personal details and medical history will be obtained and documented, and this may include photographic images of your skin condition. This information will be used exclusively for the following purposes:

- to assess and manage your medical condition;
- for administrative purposes which may include confirmation of your appointment via SMS or email;
- billing and collection purposes, including but not limited to compliance with Private Health Fund, Medicare, Workcover and Health Insurance Commission requirements;
- disclosure to health care professionals outside of this practice through referrals or medical reports;
- disclosure to other doctors in the practice, locums and trainees attached to the practice for the purpose of patient care and teaching.
- for sending me Hope Dermatology Newsletters by email

I consent to Hope Dermatology using my personal information in the ways outline above.

I understand that Consultations are not bulk billed &/or not payable by private health insurance, and fees are payable on the day of consultation. I also understand that if there is a need for a procedure or treatment, there is an additional fee for these.

How did you hear about us? (CIRCLE)

Internet search / word-of-mouth / print advertisement / social media (instagram/facebook) / Dr recommended

Please TICK if any of the following skin conditions concern you:

Facial redness/Veins	[ ]	Sensitivity to SPF/sunscreen	[ ]	Acne Scars	[ ]
Sun spots/Sun damage	[ ]	Skin texture /Ageing skin	[ ]	Congestion	[ ]

Signed: X_____ **Patient Name:** _____ **Date:** _____