Pymble Dermatology

NEW PATIENT REGISTRATION & CONSENT

Welcome to Pymble Dermatology. Our aim is to provide you with the best possible healthcare. Please complete all sections and read the Personal & Health Information Consent section at the end of this form. Should you have any queries please speak with our receptionist.

PATIENT DETAILS

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master

First Names: _____ **Surname**: _____

Date of Birth: _____ **Email**: _____

Gender: Male /Female

Ethnicity: Aboriginal/Torres Strait Islander Origin: Yes/No

Address: _____

Suburb: _____ **Postcode**: _____

Phone (H): _____ (W): _____ (M): _____

Medicare No: _____ **Position on card**: ____ **Expiry**: ___/_____

Private Health Fund: _____ Member No: _____

Concession Cards

Aged or Disability Person No: _____ Expiry: _____

Dept. Veteran Affairs Card No: _____ ☐ White ☐ Gold Expiry: _____

Health Care Card No: _____ Expiry: _____

(Please present your concession card to the receptionist for verification)

Referring Doctor _____Specialist/GP (circle one)

Usual GP _____ GP Phone number: _____

NEXT OF KIN

Next of Kin Details (Family member or friend)

Name: _____ Relationship: _____

Contact Ph: _____

Parent/Guardian's Full name (if patient is on parent's medicare card)

Mr/Mrs/Ms_____ **Date of Birth:** _____

Medicare Number: _____ No. in front of name: _____ Expiry: ___/____

PATIENT GENERAL HEALTH

List any blood thinning Medications: _____

Do you have pacemaker or implanted electronic device: Yes/No

Known Allergy to medication/Local Anaesthesia: _____

HOW DID YOU HEAR ABOUT PYMBLE DERMATOLOGY?

☐ Referred by Doctor ☐ GP or ☐ Specialist

☐ Website: pymbledermatology.com.au ☐ Australasian College of Dermatologists Website

☐ Google ☐ Yellow Pages ☐ White Pages ☐ Personal Referral: _____

Other: _____

ALL CONSULTATIONS ARE PAYABLE AT THE TIME OF SERVICE

Unfortunately, we do not bulk bill, however for your convenience we can accept EFTPOS, Visa, MasterCard, cheque and cash

Pymble Dermatology

AUTHORISATION AND CONSENT TO PHOTOGRAPHY

I, _____ _____ hereby consent that photographs can be taken of me by Pymble Dermatology practice. Pymble Dermatology respects our patients' right to privacy and informed consent for procedures within the practice including photographic records. I understand that these photographs form an essential part of my medical record as well as my preoperative and postoperative assessment. I understand and consent to my photographs being used by Pymble Dermatology for medical research, teaching and or patient education purposes. I understand that I will not be identified by name in any such use of these photographs, however in some circumstances the photographs may portray features that shall make my identity recognisable. I give permission for Pymble Dermatology to contact me by telephone and if necessary leave a message. I have read all of the above and all my questions have been answered.

Signature: _____ Date: ___/___/_____
Guardian (if patient less than 18 years old)/Carer

PERSONAL AND HEALTH INFORMATION CONSENT

A copy of our privacy policy is available at the reception and website
www.pymbledermatology.com.au

Pymble Dermatology is collecting your health information to provide you with health services. Please read and sign below to give approval for this information to be collected and stored. Your medical information will be used exclusively for providing health care in the following way:

• To gain a history, diagnoses and provide treatment where necessary;
• Administrative purposes in running this Practice, which may also include confirmation of your appointment.
• Writing reports to your Doctor and other Doctors involved in the provision of healthcare, and the storing of reports provided to this Practice by other Medical Specialists; and
• Billing and collection purposes, including but not limited to compliance with Private Health Fund, Medicare and Health Insurance Commission requirements. You may gain access to your health information by writing to us. If you do not consent to providing us with your health information we may be unable to provide you with health services.

I consent to Pymble Dermatology collecting my health information.

Signature: _____ Date: ___/___/_____
Guardian (if patient less than 18 years old)/Carer

I authorize Pymble Dermatology to discuss my care or release my medical documentation to the following people

Name:_____ Relationship:_____(eg :Son/Daughter/Carer)