

## Patient Registration Form

230 York St, South Melbourne VIC 3205

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www.hopedermatology.com.au

Title: Mr/Mrs/Ms/Miss/Mst/Dr/Prof/Other \_\_\_\_ (circle) First Name: \_\_\_\_\_

Surname: \_\_\_\_\_ Known As: \_\_\_\_\_ Gender: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

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: 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 from referring doctor): \_\_\_\_\_ Suburb: \_\_\_\_\_

### 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
- for SMS of results (the doctor will confirm with you before doing so)

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)

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

### Are you interested in new skin care products/cosmetic dermatology services? (CIRCLE)

(for future services offered at this clinic) - YES/NO

Signed: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_