inner sydney dermatology

Patient Registration

Please print these forms, fill in your details (please print clearly) and bring with you to your consultation.

Your Details:

Title:….. Surname…… Given names:…….

Address:……..

Suburb:……. Postcode:…….

Date of birth: …../….. /….. Age:…… Sex: M / F (please circle)

If under 16, name of parent/guardian: …….

Telephone: H:……. B:…….. M:…….....

E-mail:…….

Occupation:……

Medicare card no:…… Reference no:.… Expiry:……

Language spoken at home:……..

Pensioners/DVA Card Holders:

Pension no:…… Expiry:……..

DVA/Repatriation no:…… Card colour: white / gold

Private Health Insurance:

Name of fund:……..... Reference no:…… Member no:……

Referring Doctor:

Name:…….

Address:…….

Phone:……

Family Doctor:

Name:……..

Address:……..

Phone:…….

Current Medications:

…….

…….

…….

…….

…….

Allergies:

…….

Next of Kin / Person to contact in case of Emergency:

Name…… Relationship to patient:……..

Address:……

Suburb:……...Postcode:……

Settling your Account:

Consultation fees are payable on the day.
Inner Sydney Dermatology accepts Mastercard, Visa, EFTPOS and Cash.
Non-attendance at an appointment may result in a cancellation fee being charged

Privacy /Your Personal Health Information:

We acknowledge our obligations to you under the Privacy Amendment (Enhancing Privacy Protection 2012) Act 2012 and the Health Records and Information Privacy Act 2002. We assure you that both your privacy and dignity will be maintained at all times. Medical records will be held relating to your medical treatment. The contents of your medical records will only be divulged with your consent or where required by law.

PRACTICE/PRIVACY POLICY
inner sydney dermatology

I …….
(Given Name) (Surname)

by my voluntary attendance at Inner Sydney Dermatology, consent to the attending Dermatologist:

1. Recording and storing my personal health information for the purpose of my care and well-being, and in accordance with the current legislation, within the practice's computerised and hard copy systems.

2. Recording notes relevant to the reason for my attendance and allowing the practice staff access to my records for billing and administrative purposes.

3. Arranging diagnostic tests, relevant to my condition. Such requests may contain reference to personal details.

4. Corresponding with my local or referring doctor, and/or other relevant health personnel.

5. Arranging consultant advice if indicated, writing to the consultant and including diagnostic reports in the referral, along with relevant personal details, and allowing the practice to retain resulting reports.

6. Taking and storing medical photography for the purposes of clinical monitoring and research (with personal details de-identified)
I consent to these photographs being used for teaching purposes with appropriate masking of identity: yes / no (Please note that a request for your photographs not to be used for teaching purposes will not compromise or affect your treatment in any way).

7. I understand that payment of my account, in full, is my responsibility and that Medicare/health fund/insurer might not cover the total amount invoiced. I am responsible for any further costs that might be incurred resulting from my not paying my account in full by the due date.

8. I understand that there may be additional charges incurred during my consultation. These may include extra procedures conducted by the doctor and/or specimens sent off for pathology.

Signature: …… Date:……