Title: **First Name:** **Surname:**

Known As:

Address:

Date of Birth:

If under 18 years of age and you would like us to submit your claim to Medicare please advise parents' details:

Parent Full Name:
Parent Date of Birth:
Parent Medicare Reference Number:

Telephone - Home: **Work:**

Mobile: **Email:**

Emergency Contact: (Name, Relationship, Phone Number)

Medicare Number:

Medicare Ref No.(next to name): **Expiry**: __/__/__

Private Health Fund: **Member No.**:

AGED Pension Card No.: **Expiry**:

Veteran Affairs No.: **Gold** or **White** Card (please circle)

Usual GP - Name & Address (If different to referring Dr):

Current Medications (please list):

Allergies (please list):

What are your skin problems and what treatments have you had/use now ?

Continued Over Page

I _____
(Given Name) (Surname)

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

1. Recording and storing my personal details, as per the practice policies and procedures, within the practice's computerised and hard copy systems. This may include accessing the Government "My Health Record".

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. This practice uses a variety of methods to communicate with you and health professionals. These include paper mail, phone calls, SMS, email and fax. None of these methods are absolutely secure from interception.

7. 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.

8. 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.

9. 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: _____