PRESTON DERMATOLOGY
& SPECIALIST CENTRE

PATIENT REGISTRATION FORM

First Name: Family Name:

Title: Gender: Preferred Name:

Address:

Postcode:

Date of Birth: Occupation:

Phone:BH AH: Mob:

Email:

Emergency Contact Name:

Relationship: Contact Phone No:

Name of your GP (if different to referring doctor):

Clinic: Phone:

Medicare Number: ☐☐☐☐–☐☐☐☐–☐☐ Ref No. *(to the left patient name):* ☐ Exp:__/___

Pension or Health Care Card No: Exp:__/___

Veterans Affairs (DVA) No: Gold Card: ☐ White Card: ☐

PRIVATE HEALTH INSURANCE

Fund Name: Membership Number:

Level of Cover: Co-payment/excess, if known:

PAST MEDICAL HISTORY

	Yes	No
Eczema or Psoriasis	☐	☐
Skin Cancer (melanoma, BCC, SCC)	☐	☐
Bleeding Disorder	☐	☐
Diabetes requiring Insulin or Tablets	☐	☐
Currently Pregnant	☐	☐
Current Anticoagulants (i.e. Warfarin, Plavix, Iscover, Pradaxa)	☐	☐
Cardiac Pacemaker	☐	☐
Allergies	☐	☐

Please specify:

FULL PAYMENT IS REQUIRED

Full payment of the account is required on the day of the consultation and can be made by cash, EFTPOS or Credit Card (excluding Diners and AMEX cards). Debt Recovery Fees of up to 25% of the outstanding account may apply for recovery of unpaid accounts.

ABOUT YOUR PERSONAL HEALTH INFORMATION

The personal health information that you provide during your consultation and subsequent treatment will be collected for the purpose of providing you with high quality health care. Our policy is to protect your privacy and this information willonly be disclosed to other health care workers where necessary or required under legislation. Medical photography may constitute part of your medical record but may also be used for medical education purposes. I agree and consent to my health information being used in accordance with the Victorian Health Records Act, 2001.

Signature: Date: