Patient Registration

Surname:______________________________First Name:______________________

Known as: _____________________________________Date of Birth:___/___/____

Address:____

Suburb:___________________________ State:___________ Postcode:___________

Phone Home:_______________Work:______________ _Mobile:________________

Email:____

Medicare number: _ _ _ _ _ _ _ _ _ _ _ _Ref. No: __ Expiry _ _/_ _

HCC/Pension number (please circle): __________________________ Expiry:_ _/_ _

DVA Card No.: ____________________ Gold Card: No □ Yes □ Expiry:_ _/_ _

Current Occupation:____

Next of Kin/Carer Name :____

Mobile:_______________________ _ Relationship:___________________________

Medical History

Do you have any allergies to medicines or anything else? No □ Yes □

To what?_________________________Reaction_____________________________

Health Information Collection and Use Consent Form

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.
We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- To comply with any legislative or regulatory requirements eg notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

Please note: Requests for pathology may incur an additional cost which will be forwarded to your home address. A component of these additional costs can be claimed through Medicare.

☐ I give my consent for family / carer/ other__________________ to be able to access my medical records.

☐ I would like to receive the monthly Melbourne City Dermatology newsletter & notice of special offers via email.

☐ I have read the information above and understand the reasons why my information must be collected.

Patient's Signature __________________________ Date_______/________/_______