NORTHERN SYDNEY DERMATOLOGY PATIENT REGISTRATION

Patient Details: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: _____

First Names _____ Last Name _____

Known as _____ Date of Birth ___/___/_____ Male ☐ Female ☐

Residential Address _____

_____ State _____ Postcode _____

Postal Address (if different) _____

_____ State _____ Postcode _____

Telephone: Home _____ Work _____ Mobile _____

Personal Email _____ Occupation _____

Medicare No. | | | | | | | | | | | | Ref No | | Valid To | /

Private Health Insurance Fund _____ Number _____

Pension ☐ Entitlement No. _____ Valid to _____

Department of Veterans Affairs File No. _____ Gold ☐ White ☐

If White Card for what condition? _____

Parent/Guardian (If not patient) Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: _____

First Name _____ Last Name _____

Address _____

_____ State _____ Postcode _____

Emergency Contact (Next of Kin)

Name _____ Relationship _____

Telephone: Home _____ Work _____ Mobile _____

If Northern Sydney Dermatology needs to contact you and leave a message may we use your:

Home: Yes ☐ No ☐ Work: Yes ☐ No ☐

Mobile: Yes ☐ No ☐ Email: Yes ☐ No ☐

GP (if not referring doctor): _____ Suburb _____

Medical Information

Medications and/or Creams: _____

Allergies: Nil Known ☐ Yes ☐ (give details) _____

☐ Pacemaker or defibrillator ☐ Artificial Heart Valve ☐ Artificial Joint _____

☐ Blood Thinning Medications (eg Warfarin, Aspirin, Cartia, Plavix, Vit E) _____

NOTE: Should your situation or medical information ever changes in the future please ensure you advise us prior to treatments

Are you comfortable to receive special offers and updates on new treatments or information about the practice by your EMAIL only ☐ Yes ☐ No

NORTHERN SYDNEY DERMATOLOGY PATIENT REGISTRATION

Northern Sydney Dermatology complies with the provisions of the Commonwealth Privacy Act and the National Privacy Principles as they relate to the collection and management of health information. Please ask our staff if you would like more information.

I consent to Northern Sydney Dermatology recording and storing the information I have provided in my computerised medical record. Yes ☐ No ☐

In the event that I need to be referred for further tests and/or investigations, I give my consent to my doctor disclosing essential personal and health information for that purpose. Yes ☐ No ☐

I consent to Northern Sydney Dermatology using my information to contact me to remind me when procedures or skin checks are due. Yes ☐ No ☐

I consent to photographs being taken for use in my personal medical records Yes ☐ No ☐

I consent to my de-identified photographs being used for teaching purposes. Yes ☐ No ☐

I consent to my de-identified photographs being used for public education, provided I am notified prior to this occurring. Yes ☐ No ☐

I understand that all fees and charges are payable at the time of consultation and that Northern Sydney Dermatology may give certain personal information about me to a credit reporting agency for failure to pay outstanding invoices. Yes ☐ No ☐

I understand that there may be additional charges incurred beyond the consultation fee if any treatment or procedure is required (eg a biopsy or dry ice treatment). Yes ☐ No ☐

I understand that any specimen obtained will be sent to a pathology provider for examination and they will send me a separate invoice. Yes ☐ No ☐

How did you hear about Northern Sydney Dermatology?

☐ General Practitioner or other Doctor
☐ Friend or Relative
☐ Staff Member
☐ Cinema Advertising ☐ Roseville ☐ Cremorne
☐ Northern Sydney Dermatology Website
☐ Northern Sydney Dermatology Brochure
☐ Other Internet Website
☐ Other: _____

Areas of Interest

Are you interested in receiving information on treatment possibilities relating to the following?

☐ Skin Care Advice
☐ Rejuvenating Facial Peels
☐ Facial Peels for Acne
☐ Facial Peels for Pigmentation
☐ Smile, Frown or Forehead Lines
☐ Cheek enhancement
☐ Lip Aging, Lines or Thinning
☐ Collagen Production Treatment
☐ Microdermabrasion
☐ Home use of Cosmeceuticals
☐ Acne scars or other scars
☐ Botox™ or Filler
☐ Excessive Perspiration
☐ Milia/Whitehead/Blackhead Removal
☐ Leg Vein reduction
☐ Hair Removal
☐ Red Face, Chest or Neck
☐ Brown marks – face, hands, legs, chest
☐ Skin Photography
☐ Sun Damage
☐ Skin Texture and Quality
☐ Complementary skin care consultation

Other _____

Please sign below to indicate your consent and understanding in relation to the information contained on this registration form. Please ask our staff if you would like more information or have any concerns.

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____