

Information in preparation for your appointment

Your personal details

Full name		Date of birth	
Title (Mr/Mrs/Ms/Dr etc.)	Preferred name		Male Female
Address			
Suburb		State	Postcode
Email address			
Telephone	Home	Work	Mobile
Which of the above is your preferred phone number to contact regarding results, recalls or an appointment?			
Emergency contact name		Relationship	
Emergency contact number			
We can send an SMS message to your mobile phone to confirm your appointment or advise of a change. If you DO NOT wish for us to extend this service to you, please tick this box			

Health care details

Medicare number		Reference number	Expiry
Pension or Health Care Card number			Expiry
DVA Gold Card	or	DVA White Card	Member number
Private Health Insurance	Yes No		
If yes, please select	Extras only	Hospital only	Extras + Hospital
Name of Private Health Provider		Membership number	

Are you attending the practice for a full skin examination? If so...

1. Ladies, please remove all make-up before attending your appointment.
2. Please note that we do not offer a service for removal of moles that are of only a cosmetic/aesthetic concern.
3. Some skin cancers are found on areas not commonly exposed to the sun. For this reason a full skin check involves checking from the head to the soles of the feet. This will necessitate you undressing to your underwear. The doctor will ask if she/he may look underneath your underwear during this examination. You are welcome to bring an accompanying person to the appointment or a staff member can act as a chaperone upon request.

I AGREE to a full skin examination and understand the requirement of undressing to my underwear.

I DO NOT AGREE to a full skin examination and therefore understand that as it is not a full examination and that potentially serious skin conditions could be missed.

Your signature _____ Date _____

Personal medical history

Name of usual GP			
Do you have a past history of skin cancer or suspicious lesions? Yes No			
Please list any treatment/surgery and approximate date of treatment			
Date	Site of treatment/surgery (i.e. scalp, face, left leg etc)	Performed by	
Melanoma history in your family?	Yes	No	
Are you of Aboriginal or Torres Strait Islander origin?	Yes	No	
Please tick the following for any history of:			
Asthma	Diabetes	Bleeding disorders	Excessive bruising
Headaches	Blood clots	Heart related problems	Smoking ____ per day
Please answer the following for any history of adverse reactions			
Previous reaction to anaesthetics? Yes No			
Previous reaction to other medications? Yes No			
Allergies? Yes No	If yes, please provide details		
Previous severe reaction to adhesive tape etc? Yes No			
Previous reaction to antiseptic lotions or creams? Yes No			
Previous reaction to local anaesthetic agent? Yes No			
Please list your current medications (including blood thinning medications such as Aspirin, Warfarin or Clopidogrel as well as any over the counter medications such as Apririn or Glucosamine)			

Please tick each box and initial once you have read and understood the below items.

Your privacy

In accordance with the Privacy Act (1988) all information collected in this practice is treated as sensitive information. To protect your privacy, this practice operates in accordance with the Act.

We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone number etc.

Selected information may be disclosed to various other health services involved in supporting your health care management (e.g. pathology, radiology, hospital or specialists).

If you have any questions regarding the management of your personal health information or need to arrange to access your records, please ask reception staff or your doctor, as appropriate.

Patient consent to collect information

To ensure quality and continuity of patient care, a patient's health information may need to be shared with other health care providers/diagnostic facilities. Some information about patients is also provided to Medicare and private health funds, if relevant, for billing and medical rebate purposes.

I consent to images (still photographs or video) being taken for record keeping, therapeutic monitoring and education purposes.

Account conditions

Payment of a consultation account is due on the same day of service, for all other accounts, payment is due within 30 days of the date of the invoice. If any portion of the account should be overdue, then the full balance of the account will become due and payable on demand.

The patient agrees that if the account is not paid by the due date that the account may be lodged with a collection agent for recovery, and in such circumstances that the patient will bear an account surcharge of 25% to cover the agent's commissions. In the instance of legal action, the patient agrees to bear all legal costs and disbursements incurred in the recovery of the debt.

Medicare electronic claiming

I authorise this practice to lodge this claim electronically with Medicare and for Medicare to return, where necessary, updated Medicare details.

I _____ understand and consent to the above.

Your signature _____ Date _____