Northside Dermatology

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PATIENT DETAILS

Mr/Mrs/Ms/Miss/Other____
Title (Please circle one) First Name Middle Name Surname

Known As (if different to above): ____________________ Occupation: ____________________

Address: ______________________________ Home Phone: ____________________

Suburb: ______________________________ Work Phone: ____________________

State: ____________ Postcode: ______________ Mobile: ____________________

Date of birth: ________________ Email: ______________________________________

Are you happy to receive SMS/Email messages in relation to your medical care and as an appointment reminder? ◯ YES ◯ NO

Medicare No.: ______________________________ Reference Number on Card: ______________

Do you have a Heath Care Card? ◯ YES, ◯ NO Number : ________________________Expiry: _____

Do you have a Pension Card? ◯ YES, ◯ NO Number : ________________________Expiry: _____

Do you have a DVA Card? ◯ YES, ◯ NO Number: ________________________Expiry: _____
◯ WHITE ◯ GOLD

DETAILS OF YOUR HEALTH CARE PROFESSIONALS

We routinely send correspondence to your referring doctor. Please list other doctors you would like correspondence sent to:

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DETAILS OF NEXT OF KIN

Name: ________________ Relationship to Patient: ______________Best Contact Number: ____________

PLEASE AVOID WEARING MAKE UP ON THE DAY OF APPOINTMENT- WE GENERALLY NEED TO EXAMINE THE SKIN WITHOUT MAKE UP

Are you interested in talking to our therapist about skin care advice, laser treatment and rejuvenation options? ◯ YES ◯ NO

Are you interested in receiving our email newsletter regarding skincare advice, email-only promotions and updates? ◯ YES ◯ NO

How did you find us? ◯ GP ◯ Referral Online Search ◯ Family/Friend Recommendation ◯ Other

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PRIVACY STATEMENT & MEDICAL PHOTOGRAPHY

We take your personal & medical privacy seriously and in accordance with the Australian Privacy Principles of the Privacy Amendment Act 2012. Your information is not disclosed to any third party unless a written signed authority is provided by you or if requires by law. Correspondence is almost always sent back to the referring general practitioner. In some circumstances, your medical information may be disclosed to other treating doctors or a health authority if there is a clear benefit to the health and wellbeing of yourself or the public. Medical photography is utilised for the reference & documentation of your condition. At times, your photographs may be used for teaching in a way that does not reveal your identity. By signing below, you understand and consent to your information & photographs to be collected & used as described above by Northside Dermatology. PLEASE NOTE THIS IS A PRIVATELY BILLED CLINIC. BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ THE FEE SCHEDULE GIVEN TO YOU AND AGREE TO PAY THE ASSOCIATED FEES INVOICED BY NORTHSIDE DERMATOLOGY.

PLEASE PRINT YOUR NAME AND SIGN: ____

DATE:____________________