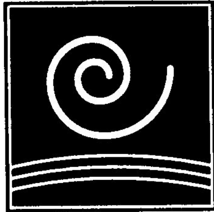

ST LEONARDS DERMATOLOGY & LASER

TITLE: MR / MRS / MS / DR OTHER:___________________________

FIRST NAME:___________________________________MIDDLEINITIAL:_________

LAST NAME: ______________________________DATE OF BIRTH: _____/_____/_____

ADDRESS: ____

______________________________________POSTCODE:__________________

PHONE: (H)_________________________________(W):______________________________

MOBILE: _________________________________MARITAL STATUS: __________________

EMAIL: ____

MEDICARE NO: REF(__)____ EXP DATE:__________

VETERANS AFFAIRS NO: ___________________________ARE YOU A PENSIONER: YES / NO

PENSION NO: ___________________________________EXP DATE:____________

NEXT OF KIN:_____________________________NEXT OF KIN PH:______________________

Please tick the following	YES	NO
Have you ever had a reaction to a local anaesthetic?	☐	☐
Are you on any medication that could affect an operation (eg Aspirin)	☐	☐
Are you allergic to any drugs	☐	☐

If yes please list allergies and/or drugs

____

____

MEDICARE ONLINE CLAIMING

Following payment of your account, we can submit your account to medicare electronically, and medicare will process your rebate directly back into your bank account. If they do not have your bank details, they will send you a cheque to the registered mailing address.
We can register you for medicare online claiming if you have not already done so. Please let the receptionist know if you would like to register. You will need your BSB No and Account No

Please tick if you would like us to submit your account to medicare ☐

No I would prefer to make my own medicare claim ☐

PLEASE TURN OVER

ST LEONARDS
DERMATOLOGY & LASER

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Your dermatologist may determine that it is necessary or helpful to obtain a photograph /recording of your skin condition to assist with treatment. This will form part of your medical record and will be held and used strictly in accordance with your wishes which can be defined below. Photographs will only be taken and used with your consent, which can be refused or limited by you and you can also withdraw this or change it in the future.

Please tick the following applicable to you:

I consent to photographs being taken for my medical records. ☐

I consent to the photographs being made available to other clinicians involved in my treatment. ☐

I consent to my photographs being used for teaching purposes or journal publications providing these are anonymised. ☐

Patient name:____

Signature: _______________________(Patient) Date: _______________________