ST LEONARDS
DERMATOLOGY & LASER

New Patient Registration

Title: MR / MRS / MS / DR/ OTHER:____

Please use full name as stated on your Medicare card

First Name:____Middle Initial:_____________

Last Name:____Date of Birth:_____/_____/______

Address:____

Suburb:____Postcode:__________________

Phone: (H):___________________(W):______________________(M):______________________

Email:____

MEDICARE DETAILS

Medicare No : REF(__)______________________________________ Exp Date:______/_______

If Patient is 13 years or younger, please provide: DOB of parent:______/______/______

Parent's position on Medicare card____

Parent's full name as per Medicare Card:____

BLUE PENSION CARD/ DVA

Do you hold a blue pension card? YES / NO

Blue Pension Card number:__________________________ Exp Date:______/______/_______

Veterans Affairs Number: ____________________ Gold / White Exp Date:_____/______/______

EMERGENCY CONTACT/NEXT OF KIN DETAILS

Emergency Contact/Next of Kin:_____________________________ PH:____________________

GP AND REFERRING DOCTOR (if different from referral)

GP Name and Clinic:____

PLEASE TURN OVER

PATIENT ALLERGIES

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

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MEDICARE ONLINE CLAIMING

Following payment of your account, we can submit your account to Medicare electronically, and Medicare will process your rebate into your bank account.

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. We will need your BSB and Account Number.

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

No, I would prefer to make my own Medicare claim ☐

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Your dermatologist may determine if 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.

I consent for my clinical photos to be used for medical and patient education: YES / NO

CONSENT TO COSTS

I understand that my consultation fee is payable in full on the day of my appointment, and any extra procedure such as skin biopsy, will be an additional cost.

Patient name:____

Signature: ___________________________________(Patient/Parent) Date: _____/_____/_____