SOUTH ROAD Dermatology

Patient Registration Form

Title: _____

First Name: _____ Surname: _____

Preferred Name:_____ Date of Birth:_____

Address:_____

_____ Postcode:_____

Home Phone:_____ Mobile:_____

Email:_____

Medicare Number:_____ Ref: _____ Exp: _____

Veteran Affairs Number:_____ Exp:_____ Gold card: Yes

Next of Kin – Name: _____

Relationship: _____ Next of Kin Phone Number: _____

If patient is under 18, the following details are required for Medicare purposes:

Parent/Guardian Name: _____

Date of Birth: _____

Medicare Ref number of Parent/Guardian: _____

Do you consent to receiving results via SMS? Yes

Name and address of your preferred pharmacy, in case scripts need to be sent or faxed:

_____

Any additional Doctors who you would like to be copied into correspondence and results:

_____

Our doctors may take photos of your skin to monitor changes. These will be retained in your personal record only. Do you consent to medical photography? Yes

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Privacy and Consent

South Road Dermatology collects information from you for the primary purpose of providing quality health care. Federal Privacy Law requires your consent to this. We need your personal details and full medical history (**which may include photographic records**) so that we may properly assess, diagnose, treat and manage your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice, which may include confirmation of your appointment via SMS or email
- Billing purposes - including, but not limited to, compliance with Medicare and the Health Insurance Commission requirements.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports of results returned to us following the referrals.
- Disclosure to other doctors, locums etc in the practice for the purpose of patient care and teaching.
- Emergency situations whereby medical officers/hospitals may require access to patient notes for treatment purposes.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters or SMS which may be sent to you regarding your health care and management.
- Please note: Requests for pathology may incur an additional cost which will be forwarded to your home address. A component of these additional costs can be claimed through Medicare.

CONSENT

- I understand for security purposes the common areas at South Road Dermatology are under CCTV video surveillance.
- I have read the above information and understand the reasons why my information must be collected.
- I understand that I am not obliged to provide any information requested, but that failure to do so might compromise the quality of the health care and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld and that an explanation will be given to me in this circumstance.
- I understand that if my information is to be used for any purpose other than the above, South Road Dermatology will seek my consent prior.
- I consent to South Road Dermatology using my personal information in the ways outlined above.
- **I understand that Consultations are not bulk billed &/or not payable by private health insurance, and fees are payable on the day of consultation.**
- **I also understand that if there is a need for a procedure, such as a biopsy, curettage, cryotherapy, cortisone injection, surgical excision, or any other treatment there will be additional fee for these.**

Patient signature_____ Date _____

Please email completed forms to: registration@southroaddermatology.com.au or fax to 9088 8488