# SOUTHERN DERMATOLOGY

## PATIENT REGISTRATION FORM

### PERSONAL DETAILS

**TITLE (PLEASE SELECT) Dr / Mr / Mrs / Miss / Master**

| | |
|---|---|
| Surname: | Date of Birth: |
| Given Name: | Known as: |
| Address: | |
| Suburb: | Postcode: |
| Phone: | Mobile: |
| Occupation: | |
| Email address:<br>By supplying an email address, you consent to the practice contacting you via this method. Please supply a private , secure email address for this purpose. | |

### ACCOUNT DETAILS

| | | |
|---|---|---|
| Medicare Card: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ | Patient Ref No: | Expiry Date: |
| Veterans Affairs: | Gold Card / White Card (Please circle) | |
| Aged Pension Card:<br>Govt Health Care Card: | Expiry Date: | |

### ACCOUNT HOLDER

| | | |
|---|---|---|
| Name: | Relationship: | DOB: |

| | | |
|---|---|---|
| Medicare Card: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ | Patient Ref No: | Expiry Date: |

### MEDICAL CONTACTS

| | |
|---|---|
| Usual GP: | Clinic: |
| Address for Correspondence: | |

### EMERGENCY CONTACT

| | | |
|---|---|---|
| Name: | Relationship: | Phone: |

**Informed Consent:** The above information is true to the best of my knowledge. In accordance with standard business practice, I fully understand payment is required at the time of consultation. Cash, credit cards (MASTERCARD/VISA) and EFTPOS are accepted. There may be additional charges for tests/procedures required to assess the condition. Your account may be partially claimable from Medicare for the consultation and any additional tests. All account and payment queries should be directed to the reception team.

☐ I acknowledge that I am personally liable for fees resulting from consultations. In the event where my account is overdue and referred to a collection agency and/or law firm, I will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs.

☐ I give consent to receive pathology results via SMS/email.

☐ I give my consent for the practice to take medical photography, and understand that these form part of my medical record.

| | |
|---|---|
| Patient name: | Guardian name: |
| Patient signature: | Guardian signature: |
| Date: | |