laserdermatology
MEDICAL, SURGICAL & COSMETIC

503 Elgar Road, Mont Albert North 3129 **Phone** 03 9890 1844

Patient Registration Form

○ Mr ○ Ms ○ Mrs ○ Miss
(Please select one)

Name _____ _____ Date of Birth _____
First Name Surname

Address _____ Postcode _____

Phone _____ _____ _____
Home Business Mobile

Email _____ I am happy to receive practice updates ○ Yes ○ No

Pension _____ Expiry date _____ Medicare No. _____ Ref No. _____

Occupation _____ Medicare Expiry Date _____

Person responsible for account _____

Address _____ Phone _____
(if different from above)

Referring Doctor _____ Address _____

Name of GP _____ Address _____
(if different from above)

How did you find out about the clinic? _____

General Health History

Have you suffered any serious illness? _____

What operations have you had? _____

Please indicate if you have a history of the following:

Allergies _____ Rheumatic fever _____ Blood clots, thrombosis _____

Heart trouble _____ Blood pressure _____ Fainting _____

Epilepsy _____ Kidney disease _____ Hepatitis _____

Bleeding tendency _____ Diabetes _____ Lung disease _____

Other _____

Are you at risk of developing HIV, AIDS or Hepatitis? _____

Is there anything of a confidential nature you wish to discuss with the doctor / nurse? _____

Allergies: Are you allergic to any medicines, lotions or tape? Please list _____

Bleeding tendency: Are you subject to prolonged bleeding or frequent nose bleeds? _____

Cortisone: Have you ever been given cortisone or steroid tablets or injections? Please specify when _____

Medication: Please list any current medication (including herbal / alternative) _____

_____

Patients, please note - if you have been referred by another doctor:

Patients are advised that this practice does not bill Medicare direct for Patient Accounts. GP referrals are valid for 12 months and Specialist referrals for only 3 months. Any patients attending without a current referral will still be charged the specialist rate but will be ineligible for Medicare rebate at the specialist level. Dr Bekhor or his staff cannot request a backdated referral from your GP. It is your responsibility to negotiate referrals from your doctor. **Please note: due to a change in the structure of our practice, we are no longer able to accept indefinite referrals. Thank you for your assistance.**

WorkCover and TAC patients must provide correct details of the organisation accepting liability for payment of services, including their employer, insurance company and claim number **before** treatment is undertaken.

You will be given your account after your consultation, at which time settlement will be required. Visa, Mastercard and EFTPOS credit facilities are available. **THE TERMS OF CONTRACT ARE SETTLEMENT OF ALL CONSULTATION ACCOUNTS ON THE SAME DAY.**

Signed _____ Date _____

Please Turn Over...

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Privacy Consent Form

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice, including telephone confirmation of appointments.
- Billing purposes, including compliance with Medicare and 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 or results returned to us following the referrals.
- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care, teaching and research. Please let us know if you do not want your records accessed for these purposes and we will note your record accordingly.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my 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. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

I consent to the use of my non-identifying clinical photographs for educational purposes in the practice / at medical lectures / medical journals, or for marketing purposes.

Signed _____ Date _____

Witness _____