SkinDoctor TOOWOOMBA

PATIENT REGISTRATION & INFORMATION FORM

We are committed to providing our patients with the best care. To do this it is essential that your health record is kept up to date and accurate. Please Print and Place ☒ in all applicable boxes

Title	☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mast
Surname	
Given Name	Preferred Name:
Date of Birth	
Sex	☐ Male ☐ Female
Occupation	
Street Address	Town/Suburb: Postcode:
Postal Address (if different from above	Town/Suburb: Postcode:
Phone Number	Home: Mobile: Work:
Email	
Preferred Method of Contact	☐ Home phone ☐ Mobile phone ☐ Mail ☐ Email
Reminders	I consent to being contacted with a reminder to maintain my appointments and health. ☐ Yes ☐ No Consent for reminder by SMS ☐ Yes ☐ No
Next of Kin/Emergency Contact	Name: Address: Contact No: Relationship to Patient:
Medicare Card Number	Ref No: Expiry: ____/_____
DVA Card Number	DVA Gold ☐ or White Card ☐ Expiry: ____/_____
Concession Card Number	☐ Pension ☐ Health Care Card Expiry:____/____/____
Private Health Cover	☐ Yes ☐ No Health Fund Name:

Doctors working at this clinic are General Practitioners with special interest in Skin Cancer Medicine and Primary Care Dermatology. They are not Dermatologists. As a general guide, we recommend annual skin checks and we believe full body checks are best to enable skin cancers in their early stages to be identified and treated. You will be asked to remove your clothing, but leave your underwear on. Some skin cancers especially melanomas may occur on skin that has never been exposed to the sun. The doctor will discretely check the skin under your underwear. If you specifically do not want these areas checked please tell the doctor. It is still your option not to have a full body scan.

I consent to the following:

1. **A full body skin check** ☐ **YES** ☐ **NO**
2. **A partial body skin check of the following areas**

   _____

I take full responsibility myself for any areas I have not had checked.

Signature: _____ Date: _____

PATIENT CLINICAL INFORMATION

NAME: _____ **DOB**:_____

MEDICAL CONDITIONS

☐ Bleeding/clotting disorder ☐ Bloodborne virus e.g. HIV, Hep B, Hep C ☐ Breathing difficulties/Lung problems

☐ Diabetes ☐ Dizziness or fainting during / after procedures ☐ Heart valve problems ☐ Heart operations

☐ Immune System Disorder ☐ Pacemaker ☐ Organ Transplant ☐ Radiotherapy

☐ Require antibiotics for procedures ☐ Vascular Disease ☐ Vitamin D deficiency

Do you have any medical conditions requiring ongoing treatment or medications? ☐ Yes ☐ No If Yes, details

_____

_____

Do you have any allergies or are you sensitive to any drugs or dressings -in particular to medications, antiseptic solutions or sticking plasters? ☐ Yes ☐ No ☐ Unsure

If Yes, details:_____

Current medications (Especially Aspirin or Warfarin)

_____

SKIN CANCERS

Have you ever had a skin cancer diagnosed and treated by a doctor?

☐ Yes ☐ No ☐ Unsure

If Yes, what type/s: ☐ SCC ☐ BCC ☐ Solar Keratosis/Sunspot ☐ Other

Have you ever had a malignant melanoma in the past?

☐ Yes ☐ No ☐ Unsure

Do you have a history of melanoma in your immediate family?

☐ Yes ☐ No ☐ Unsure

If Yes, who: ☐ Father ☐ Mother ☐ Sibling (Brother/Sister) ☐ Other Relative

Do you have a history of other skin cancers in your immediate family?

☐ Yes ☐ No ☐ Unsure

If Yes, who: ☐ Father ☐ Mother ☐ Sibling (Brother/Sister) ☐ Other Relative

Which number best describes your skin?

1. Pale white skin, blonde/red hair. Always burns, never tans.
2. Fair skin. Burns easily, tans poorly.
3. Darker white skin. Tans after initial burn.
4. Light brown/olive skin. Burns minimally, tans easily.
5. Brown skin. Rarely burns, tans easily.

OTHER SKIN CONDITIONS

Have you ever had any skin conditions?

☐ Eczema / Dermatitis ☐ Psoriasis ☐ Rosacea ☐ Severe Acne ☐ Overgrown or discoloured scars

Other (please give details) _____

Current skin creams, ointments etc: _____

HEALTH INFORMATION COLLECTION AND USE CONSENT

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

Skin Doctor Toowoomba 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. Please read this consent form carefully and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare 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 referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

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 obligated to provide any information requested of me, but that my failure to do so might compromise the quality of my health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some cases where it might be legitimately withheld. I understand that I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other 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 of which I notify the practice.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records and allow us to contact you promptly about tests and results.

Signature of Patient or Guardian: _____ Date: ____/_____/_____

Name: _____

Office Use Only: Doctor _____ Nurse _____ Admin _____