SKIN WISE HEALTHcare Skin Cancer Clinic

Patient Information Form

Surname: _____ Dr/Mr/Mrs/Ms/Miss/Mast/Other

First Name: _____ D.O.B: _____

Street Address: _____

Suburb: _____ Post Code: _____

Occupation: _____

Are you Aboriginal or Torres Strait Islander? Aboriginal: Yes/No Torres Strait Islander: Yes/No

Contact Details Home Ph: _____ Mobile: _____

Work Ph: _____ Email: _____

Current GP _____

Medicare Number: __ __ __ __ __ __ __ __ __ __ Ref No (in front of name): _____ Expiry Date: _____/20____

Pension/Health Care Card: _____ Expiry Date: _____

Veterans Affairs Gold Card: _____ Expiry Date: _____

How did you hear about Skin Wise? Please circle

My GP Sports Club Word of Mouth Website Signage

Other(please specify): _____

We provide a phone or letter based recallsystem as a reminder when you are due for treatment – Would you like to be included in the system: **Y / N**

Would you accept an SMS message as a reminder for appointments and recalls? **Y / N**

Emergency Contact

In case of emergency please list a family member or contact person to whom you authorise the doctor/practice to contact:

Name: _____ Relationship: _____

Contact No: _____

PRIVACY POLICY

It is policy of Skin Wise Healthcare to maintain the security of personal health information at all times and to ensure that this information is only available to authorised Practitioners. Information may be disclosed to other organisations where required by law or if necessary contact details may be disclosed for debt recovery purposes. We have a more comprehensive Privacy Act that you are welcome to read upon request. Please ask our Reception Staff.

PATIENT DECLARATION

I understand that all accounts are to be paid on the day of the consultation. If I fail to pay the account in full I agree to pay all expenses incurred by Skin Wise Healthcare in collection of the outstanding debt. A fee may be charged for non attendance of consultations without 24 hours prior notice given.

Signed: _____ Date: _____

Skin Cancer Risk Assessment

	Please circle		Details
Previous skin cancer(s)	Yes	No	_____
Family history of skin cancer	Yes	No	_____
Fair skin and light coloured eyes	Yes	No	
Significant time working outdoors	Yes	No	_____
Use of solariums, active tanning	Yes	No	
History of severe/blistering sunburn	Yes	No	
A large number of moles (50+)	Yes	No	
Irregular moles	Yes	No	
Any spots you are concerned about?	Yes	No	_____
Any recent changes in any of your spots?	Yes	No	_____

Additional Questions

Are you a smoker?	Yes	No	
Are you taking any blood thinners?	Yes	No	_____
Are you on immunosuppressant medication?	Yes	No	_____

Allergies: _____

Person responsible for this account (ONLY FOR MINORS <16 years of age)

Parent/Guardian: Name: _____

D.O.B. _____

Address: _____

Medicare No. _____

Contact No. _____

THIRD PARTY AUTHORITY

If you wish to authorise a specific family member or contact person to call on your behalf and receive your results please specify below. If you wish to cancel or change the authorisations, you must advise the Practice in writing.

Name: _____ Relationship to you: _____

Signed: _____ Date: _____