St George Dermatology & Skin Cancer Centre

New Patient Details and Consent

Please indicate your doctor:

☐ **A/Prof Stephen Shumack** ☐ **Dr Adrian Lim** ☐ **Dr Esther Hong** ☐ **Dr Gilberto Moreno**

Mr/Mrs/Ms/Miss/Other: _____ Gender: Male / Female

Given name: _____ Surname: _____

Date of birth: _____Preferred name: _____

Address: _____

Suburb: _____ Postcode: _____

Telephone: (Home) _____(Work) _____

(Mobile) _____May we use SMS to contact you Y / N

Email Address: _____

Medicare number: _____ Patient number: _____ Expiry date: _____

DVA/Pension number: _____ Expiry date : _____

(Age Pension Card accepted ONLY)

Name of parent or guardian *if patient under 16 years of age* (head of family for billing and claiming)

Name: _____ DOB: _____ Medicare Card Reference: _____

THIS IS NOT A BULK BILLING PRACTICE

Please note that this is a private practice and fees are payable at the time of consultation

How will you be settling your account today? (Please circle)

Credit card (Visa/Mastercard/Amex) Cash EFTPOS

Consent to collect patient information

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 medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

- I understand the reasons why my information must be collected.
- 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 the above, my consent will be sought.
- 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 may notify this practice.

Patient name: _____

Signature: _____ Date: _____

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