Phone: 03 53105969

CONFIDENTIAL PATIENT QUESTIONAIRE

Thank you for spending a few minutes filling out this form.

Title: Mr / Mrs / Miss / Ms / Dr

Given Names: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____

Street Address: _____

Town: _____ Postcode: _____

Home Phone: _____ Mobile: _____

Would you like to receive reminder messages via

- ❑ SMS
- ❑ Phone
- ❑ Mail

Occupation: _____

Email Address: _____

Person responsible for account: _____

Person to contact in an emergency: _____

Phone: _____ Relationship: _____

Do you permit us to speak to this person about you? Yes / No

Local Doctor: _____

Medicare Number: _ _ _ _ _ _ _ _ _ _ _ Ref No: _ Valid to: _ _ / _ _ _ _

Veteran's Affairs Card No: _ _ _ _ _ _ _ _ Colour: Gold / White / Blue (Please circle)

Concession Card No: CRN _ _ _ _ _ _ _ _ _ _ Expiry Date: _ _ / _ _ / _ _ _ _

Card Type:

- ❑ Pensioners Concession Card
- ❑ Healthcare Card
- ❑ Commonwealth Seniors Health Card

Medical History: (please circle)

- Any history of blistering sunburn: Yes / No
- Any skin cancers cut off in the past: Yes / No
- Are you a smoker: Yes / No
- Do you faint with blood tests or medical procedures: Yes / No
- Solarium use, past or present: Yes / No
- Do you have a history of HIV (AIDS), Hepatitis B or Hepatitis C: Yes / No
- Do you have any joint replacements: Yes / No
- Any history of heart surgery: Yes / No
- Are you concerned about facial redness? Yes/ No

Other Medical Conditions:

_____

_____

Allergies to medicines, tapes or antiseptics:

_____

_____

Current Medications:

_____

_____

Please present on the day of your appointment with NO MAKE UP.

How did you hear about our clinic? (Please circle)

Friend Doctor Word of Mouth Staff Member Social Media Internet Radio Walk by

Photographic Consent

Photos are an important part of medical records. Identifiable photographs **will not** be shown to other patients or published in medical literature. Refusing or withdrawing of photographic consent will have no effect on the medical care that you receive.

I consent to photographs being taken. **Yes/No**

I understand that payment of the account is my responsibility, and that Medicare will not cover the amount in full. I accept that if I default on my account, my details will be passed on to a collection agency and a credit rating agency. I agree to pay all fees associated with collection of a delinquent account.

In the event of a biopsy or excision, I agree to pay the **out-of-pocket fee** and forward any received Medicare cheques to Horsham Skin Cancer Clinic to cover any outstanding amount for Pathology (if applicable)

Signature: _____ Date: _____