Gateway DERMATOLOGY

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PATIENT DETAILS FORM

Title: __________ First Name: ____________________________ Surname: ______________________________________

Address: ____

Suburb: ____ State: __________________ Postcode: ___________________________

Date of birth: ___________________ Marital Status: ___________________ Employment Status: ______________________

Home Phone: ____________________ Work Phone: _____________________ Mobile: _____________________________

Email Address: ___________________________________ Country of Birth: ____________________________________

Medicare No.: ____________________________ Reference No.: ________________ Expiry Date: ________________________

Private Health Fund: _______________________ Membership No.: _______________________ Hospital Cover: Y or N

DVA Card No.: ____________________________ DVA Card Colour: ______________ DVA disability: ______________________

Usual GP/Practice Name: ____

Next of kin: ______________________ Relationship: __________________ Phone Number: ____________________________

Current Medications: (including warfarin, asprin, clopidogrel/plavix or any other blood thinners) _________________________

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Known Allergies: ____

Please circle any of the following applicable: **Heart Attack or Angina** **Artificial Heart Valves or Stents** **Cardiac Pacemaker**

Stroke **Bleeding Disorders** **Diabetes (requiring Insulin or tablets)** **Recent Joint Replacement** **Infectious Diseases**

CONSENT TO COLLECT PATIENT INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We need your personal details and full medical history (which may include photographic records) so that we may properly assess, diagnose, treat and be proactive in your health care needs. This information will be used in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes - including, but not limited to, compliance with Medicare and the 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.

By signing this form, you agree that:

- 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 and that an explanation will be given in this circumstance
- 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.

Signed: ____ **Date:** _________________________________

Patient Name (Please print) ____