SDS &L

Specialist Dermatology Surgery & Laser™

DR ADAM T SHERIDAN MBBS FACD FACMS FAAFPS

PATIENT REGISTRATION FORM						
If you are suffering from cold and flu symptoms or may have been exposed to COVID-19, please inform staff immediately.						
Title *(please circle)*	Mr	Mrs	Ms	Miss	Mast	Other:
Surname						
First Name/s						
Street Address						
Suburb			Post code			
Postal Address *(If different to above)*						
Date of Birth		Occupation *(previous occupation if retired)*				
Home Phone		Mobile:		Work:		
Email						
Preferred Method of Communication *(please tick)*	Phone ○	SMS ○	Email ○			
If we need to contact you by phone, may we leave a message or send an SMS to your mobile? ***Your permission is required to protect your privacy.*** *Please circle as applicable.*	Yes	No				
Medicare No.	__ __ __ __ __ __ __ __ __ __	No. next to Name		Expiry		
Private Health Fund		Membership No.				
Level of cover *(please circle one only)*	Hospital ***and*** Extras	Hospital ***only***	Extras ***only***	Excess $		
Pension/Healthcare Card No.		Expiry Date				
DVA Card No.		GOLD	WHITE			
Referring Doctor		○	○			
Family Doctor *(if different)*						
Parent/Guardian Name *(if applicable)*						
Emergency Contact						
Relationship						

I understand that payment of all accounts is my responsibility. Accounts for treatment performed in the rooms are **payable in full at the time of treatment**. I have been quoted and understand the out of pocket expenses relating to my consultation and treatment.

Signed **Date:**

If signed by parent or guardian, please state name and address below if different from above.	
Parent/Guardian Name	
Parent/Guardian Address	

Have you been seen by Dr Sheridan previously?	
If so, which Clinic?	

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MEDICAL HISTORY							
CONDITION (please tick /answer as appropriate)						**YES**	**NO**
HEART ATTACK OR ANGINA (within last 6 months)							
DISEASE OF/OR ARTIFICIAL HEART VALVES							
CARDIAC PACEMAKER/MEDICAL DEVICES/IMPLANTS/JOINT REPLACEMENT						Circle applicable	
STROKE or EPILEPSY (within last 6 months)							
SEVERE RESPIRATORY DISEASE (such as severe asthma, chronic bronchitis, emphysema or sleep apnoea)							
BLEEDING DISORDER (such as haemophilia, von Willebrands disease or platelet disorder)							
DIABETES (requiring insulin or tablets)							
ARE YOU PREGNANT (female patients)							
ARE YOU TAKING WARFARIN OR OTHER **ANTI-COAGULANTS**							
INFECTIOUS DISEASE (Hepatitis B, Hepatitis C, HIV, TB, MRSA. COVID-19)							
COVID 19 – Are you fully vaccinated against COVID 19?						Yes / No	
PAST SKIN CANCER:	BCC	SCC	Melanoma	Other:			
TREATMENT RECEIVED FOR SKIN CANCER:							
ALLERGIES TO MEDICATIONS (please circle) If so please specify:						Yes / No	

AUTHORISATION & CONSENT TO PHOTOGRAPHY			
(please tick as appropriate)		**YES**	**NO**
I hereby consent for medical photographs to be taken of me by my doctor. I understand that such photographs may be used in my medical record.			
I consent for these photographs, *after removal of identifying information such as my name*, to be used for the purposes of medical teaching.			
I consent for these photographs, *after removal of identifying information such as my name*, to be used in medical publications, including medical journals, textbooks and electronic publications			
By consenting to these medical photographs I understand that I will not receive payment from any party. I also understand that refusal to consent to photographs will in **NO** way affect the medical care that I will receive and that if, having given my consent, I wish to withdraw such consent in the future I may do so by contacting the Practice.			
Signed		**Date**	

PATIENT PRIVACY			
The personal health information that you provide during your consultation and subsequent treatment will be used for the purposes of providing you with high quality health care. Our policy is to protect your privacy and accordingly the information you provide will only be disclosed to other members of your medical treatment team where necessary. It will however be disclosed to other organisations where required by law or where required for billing or debt recovery purposes. I have read understood and agree to the above and consent to my health information being collected by the Practice.			
Signed		**Date**	

***PLEASE NOTE: In order to obtain Medicare Rebates you are required to have a valid referral for each appointment. If you are unsure if your referral is valid, please ask reception staff.*
Payment must be made on the day of your consultation via EFTPOS, Credit Card, Cash or Cheque.
Outstanding accounts referred to our debt collecting service will incur a debt collection fee. By signing this form you are consenting to our payment policy.