SDS &L

Specialist Dermatology Surgery & Laser™

DR ADAM T SHERIDAN MBBS FACD FACMS FAAFPS

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			
Home Phone		Mobile		Work		
Email Address						
If we need to contact you by phone, may we leave a message or send a SMS to your mobile? ***Your permission is required to protect your privacy.*** *Please circle as applicable.*					Yes	No
Medicare No.		No. next to Name		Valid to:		
Name of Private Health fund			Membership No.			
Level of cover (please circle one only)	Hospital ***and*** Extras		Hospital ***only***	Extras ***only***	Excess $	
Parent/Guardian Full Name		Date of Birth:		Phone Number:		
Pension/Healthcare Card No.			Expiry Date			
DVA Card No.		Colour of Card				
Emergency Contact Details	Name		Relationship		Contact number	
Referring Doctor						
Family Doctor *(if different)*						
Is this a WorkCover/Third Party Claim? *Please circle as applicable*					Yes	No
NB – if you have answered ***Yes*** *to the above question, you will also need to complete the WorkCover/Third Party Information Form. Please ask our Receptionist for this form.*						

I understand that payment of all accounts is my responsibility. All accounts for treatment which is done in the rooms are **payable in full** at the time of treatment. We do not bulk bill, however for your convenience we can accept Cash, EFTPOS, Visa & MasterCard. Accounts relating to surgical procedures are payable within 30 days (except where no Medicare, private health fund or third party rebate is available in which case such accounts are payable prior to surgery). I also undertake to pay any debt collection expenses that may be incurred as a result of late payment or non-payment of accounts.

Signed		Date	

If signed by parent or guardian, please state name and address below if different from above.

Parent/Guardian Name	
Parent/Guardian Address	

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 PRESENT					
STROKE (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 only)					
ARE YOU TAKING WARFARIN OR ANTI-COAGULANTS					
RECENT JOINT REPLACEMENT (in the last 2 years)					
INFECTIOUS DISEASE (such as Hepatitis B, Hepatitis C, HIV, TB or MRSA)					
PAST SKIN CANCER: Type (please circle)	BCC	SCC	Melanoma		
TREATMENT RECEIVED FOR SKIN CANCER:					
ALLERGIES TO MEDICATIONS (please specify)					

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	