CENTRAL SYDNEY
DERMATOLOGY

New Patient Details and Consent

Preferred Pronoun(s), terms, and title(s): _____

Given name: _____ Surname: _____

Date of birth: _____ Preferred name: _____

Address: _____

Suburb: _____ Postcode: _____

Preferred phone: _____ Home/Work/Mobile
If mobile provided may we use SMS to contact you? Y ☐ N ☐

Email:-_____

When providing your email address to us you accept that we may send information to you if we are unable to contact you via telephone. By providing your email address you accept the risks associated with sending personal information via electronic transmission

Medicare number: ☐☐☐☐ ☐☐☐☐☐ ☐ Ref number: ☐ Expiry date: ☐☐/☐☐

DVA: ☐☐☐☐☐☐☐☐☐☐ Gold/White/Orange Expiry date: ☐☐/☐☐
If DVA White card please specify condition covered: _____

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

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.

• Costs: as this is a private practice, we do not bulk bill our services. Reception staff can quote consultation fees. All further treatments are quoted by your Dermatologist. Specimens removed during procedures are sent to a pathologist for diagnosis and they will send you an account for their costs.

• Photos may be taken during the course of your consultations. I give consent for the images to be electronically stored.

Patient name: _____

Signature: _____ Date: _____