SKIN CANCER & LASER CLINIC

PATIENT INFORMATION FORM

Title: Mr / Mrs / Ms / Miss: (please circle)

First Name:_______________ **Surname:**_______________

Middle Name:_______________ **Preferred Name:**_______________

Address:_______________

Suburb:_______________ **DOB:**_______________

Home Ph:_______________ **Work Ph:**_______________

Mobile Ph:_______________ **Occupation:**_______________

Email Address:_______________

Usual GP:_______________ **Suburb:**_______________

Medicare No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **Ref No:** ___ **Expiry:**_______________

Private Health Fund:_______________ **Membership No:**_______________

Pension/ Health Care Card No:_______________ **Expiry:**_______________

DVA No:_______________ **White/ Gold Card Holder:** (please circle) **Expiry:**_______________

How did you hear about 4D Skin Cancer & Laser Clinic?_______________

Emergency contact details:

Name:_______________ **Relationship to you:**_______________

Home Ph:_______________ **Mobile Ph:**_______________ **Work Ph:**_______________

CONSENT TO COLLECTION OF PERSONAL AND HEALTHCARE INFORMATION

As a patient of this medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. We aim to protect the privacy of your health information at all times. We require your consent to collect your personal information, including photographs, which may be used for the following reasons:

- Administrative and educational purposes, billing and disclosure to others involved in your healthcare.
- For reminders and recalls which may be sent to you via SMS, email or letter regarding your healthcare and management.
- Request to obtain/ transfer medical records and reports.

Use of email/SMS

I understand that I can choose to have information for routine reminders by email/SMS. This service is restricted to administrative purposes only to protect the privacy and confidentiality of patients as total security cannot be guaranteed. In providing an email address /mobile phone number, I acknowledge the risks and consent for my email/mobile phone number to be used for this purpose.

Patient Signature:_______________ **Date:**_______________

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Past Cancer History: (please circle)

Skin Cancer (BCC/ SCC): YES/ NO Melanoma: YES/ NO

Please list **ALL OTHER** known cancers:______________________________

Family History: (If yes, please list family member)

Skin Cancer: YES/ NO ______________________________

Melanoma: YES/ NO ______________________________

Other Cancers: YES/ NO ______________________________

Allergies: (please list all known allergies)

____

Medical Conditions: (eg: Hypertension/ Bypass/ Asthma/ Bleeding/ Clots)

____

Hepatitis B ☐ Hepatitis C ☐ HIV ☐

Past Surgery: (please list to the best of your knowledge)

____

Joint Replacements: (please date)

____

Hospital Acquired Infections: (eg: Golden Staph, MRSA)

____

Medications: (please list all current medications, including blood thinners)

____

____

Plavix ☐ Aspirin ☐ Warfarin ☐

Vitamins/ Herbal Medications: (please list)

____

Do you smoke? YES/ NO

Quantity:__________________ per day Or when did you cease? ____________________

Do you drink alcohol? YES/ NO

Quantity:__________________ per day/ week/ month