Currambine Mole & Skin Cancer Clinic

3b/94 Delamere Avenue
Currambine, WA, 6028
Telephone: (08) 9305 3005
Fax: (08)

Patient Registration Form

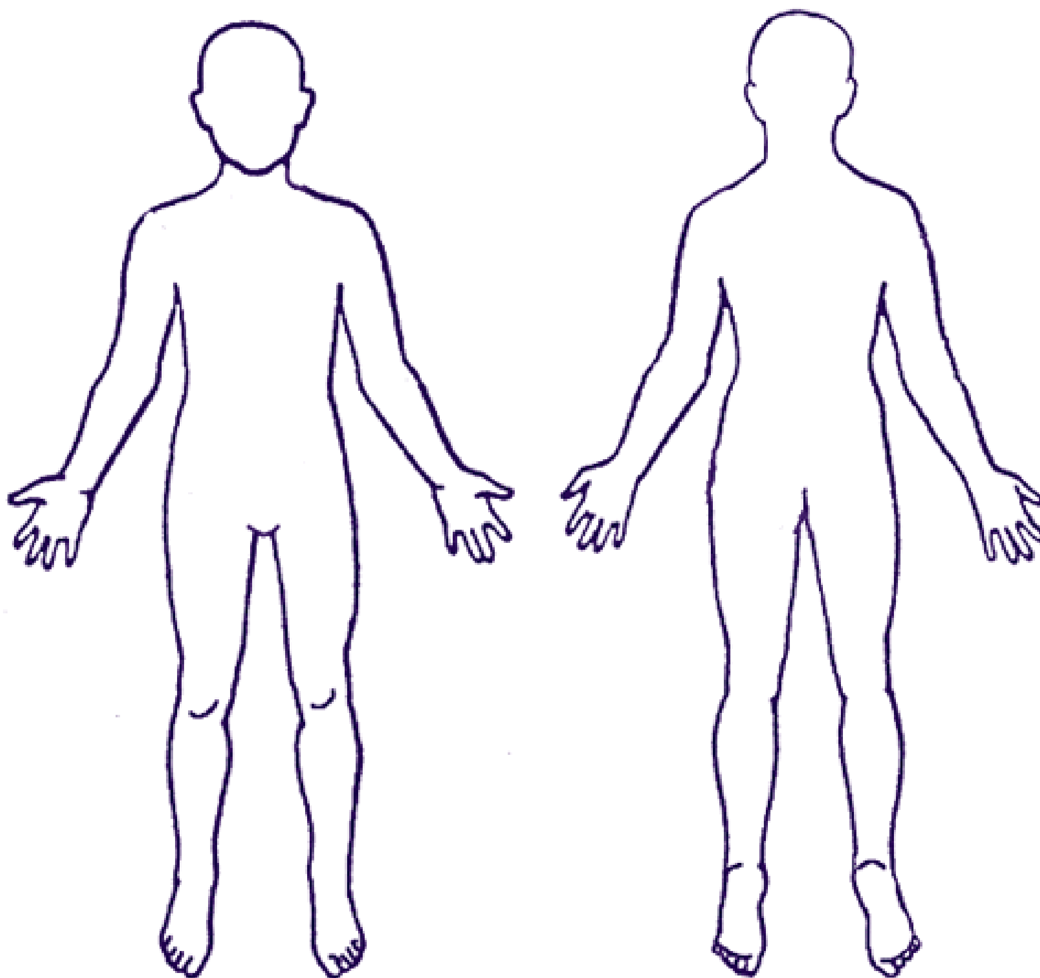
We are committed to providing our patients with the highest standards of care. In order to do this, it is essential that your health records are kept up to date and accurate.

Could you please assist us by completing the following:		
Title	☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master (please tick)	
First Name:	Middle Name:	Surname:
Known As:	Date of Birth	Sex:
Country of Birth:	Year of Arrival in Australia:	Ethnicity:
Street Address:		
Suburb:	State:	Post Code:
Home:	Mobile No:	Work:
E-mail:	Allow SMS Reminder : Yes	No (please tick)
Medicare Number:	Ref No:	Expiry:
☐ DVA Gold ☐ DVA White (please Tick)	No:	Expiry:
Pension Number	No:	Expiry:
Health Care Card Number	No:	Expiry:
Private Health Cover: Fund:	Name of	Member No:
Next of Kin Relationship:	Name: Tel:	
Emergency Contact (name and phone number of a the person we can contact if needed)	Name: Tel:	
Alcohol	☐ **No** ☐ **Yes. Number_____day/_______week/______month**	
Drug Use	☐ **No** ☐ **Yes. Type___________________ / Frequency__________________**	
Usual General Practitioner: Dr.		
Clinic :		
Address if Known:		

Where Did You Hear About Currambine Mole & Skin Cancer Clinic (please tick)

Friend / Family (Word of Mouth)	Referred from GP
Signage Out Front	Internet (Google, Website)
Clinic's Brochure	Newspaper
Other	

PLEASE INDICATE WITH AN X ON THE DIAGRAM ANY AREAS OF CONCERN



Please tick the relevant answers

Have you or any immediate family member been diagnosed with Melanoma?		
Yes:	No:	
(Myself, Mother, Father, Sister, Brother or Family Member:		
Have you ever had anything cut off your skin?	Yes:	No:
Location:	Diagnosis:	
Have you ever had anything frozen or burnt off your skin?	Yes:	No:
Location:	Diagnosis:	
Any allergies to tapes or bandages?	Yes:	No:
Any allergies to medications or injections?	Yes:	No:
(If yes, please list)		
Do you have a Pacemaker?	Yes:	No:
List any regular medication:		

Currambine Mole & Skin Cancer Clinic

3b/94 Delamere Avenue
Currambine, WA, 6028
Telephone: (08) 9305 3005
Fax: (08)

PRIVACY STATEMENT

Introduction

We are committed to protecting the privacy of patient information and to handling your personal information in a responsible manner in accordance with the Privacy Act 1988 (Cth), the Privacy Amendment (Enhancing Privacy Protection) Act 2012, the Australian Privacy Principles and relevant State and Territory privacy legislation (referred to as privacy legislation).

This Privacy Policy explains how we collect, use and disclose your personal information, how you may access that information and how you may seek the correction of any information. It also explains how you may make a complaint about a breach of privacy legislation.

This Privacy Policy is current from 2014. From time to time we may make changes to our policy, processes and systems in relation to how we handle your personal information. We will update this Privacy Policy to reflect any changes. Those changes will be available on our website and in the practice.

Collection

We collect information that is necessary and relevant to provide you with medical care and treatment, and manage our medical practice. This information may include your name, address, date of birth, gender, health information, family history, credit card and direct debit details and contact details. This information may be stored on our computer medical records system and/or in hand written medical records.

Wherever practicable we will only collect information from you personally. However, we may also need to collect information from other sources such as treating specialists, radiologists, pathologists, hospitals and other health care providers.

We collect information in various ways, such as over the phone or in writing, in person in our practice. This information may be collected by medical and non-medical staff.
In emergency situations we may also need to collect information from your relatives or friends.
We may be required by law to retain medical records for certain periods of time depending on your age at the time we provide services.

Use and Disclosure

We will treat your personal information as strictly private and confidential. We will only use or disclose it for purposes directly related to your care and treatment, or in ways that you would reasonably expect that we may use it for your ongoing care and treatment. For example, the disclosure of blood test results to your specialist or requests for x-rays.

There are circumstances where we may be permitted or required by law to disclose your personal information to third parties. For example, to Medicare, Police, insurers, solicitors, government regulatory bodies, tribunals, courts of law, hospitals, or debt collection agents. We may also from time to time provide statistical data to third parties for research purposes.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential
I, ______________________________ give my permission for my personal health information to be collected, used and disclosed as described above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.
Patient Name: (Please print) ____

Signature ____________________________ Date ____________________________
OR

My Signature below indicates that I consent to the handling of information by this practice for the purposes set out above on behalf of my child:

Name of Child: ______________________________ DOB: ______________________