Information in preparation for your appointment

MACQUARIE SKIN CANCER CLINIC.

Your personal details

Full name			Date of birth
Title (Mr/Mrs/Ms/Dr, etc.)	Preferred name		
Woman ☐ Man ☐ Non-binary ☐ Prefer not to say ☐ Or specify			
Address			
Suburb	State		Postcode
Email address			
Telephone	Home	Work	Mobile
Which of the above is your preferred phone number to contact regarding results, recalls or an appointment?			
Emergency contact name			Relationship
Emergency contact number			
We confirm your appointment or advise of any changes via SMS message. If you **DO NOT** wish to receive messages this way please tick this box ☐			

Health care details

Medicare number		Reference number	Expiry
Pension or Health Care Card number			Expiry
DVA Gold Card ☐ or	DVA White Card ☐	Member number	
Private Health Insurance	**Yes** ☐ **No** ☐		
If yes, please select	Extras only ☐	Hospital only ☐	Extras + Hospital ☐
Name of Private Health Provider		Membership number	

Are you attending the practice for a full skin examination? If so…

1. Please remove all make-up before attending your appointment.
2. Please note that we do not offer a service for removal of moles that are of only a cosmetic/aesthetic concern.
3. Some skin cancers are found on areas not commonly exposed to the sun. For this reason a full skin check involves checking from the head to the soles of the feet. This will necessitate you undressing to your underwear. The doctor will ask if she/he may look underneath your underwear during this examination. You are welcome to bring an accompanying person to the appointment or a staff member can act as a chaperone upon request.

☐ **I AGREE** to a full skin examination and understand the requirement of undressing to my underwear.

☐ **I DO NOT AGREE** to a full skin examination and therefore understand that as it is not a full examination and that potentially serious skin conditions could be missed.

Your signature _____ Date _____

Personal medical history

Name of usual GP	

Do you have a past history of skin cancer or suspicious lesions? **Yes** ☐ **No** ☐
Please list any treatment/surgery and approximate date of treatment

Date	Site of treatment/surgery (e.g. scalp, face, left leg, etc.)	Performed by

Melanoma history in your family?	**Yes** ☐ **No** ☐
Are you of Aboriginal or Torres Strait Islander origin?	**Yes** ☐ **No** ☐

Please tick the following for any history of:

☐ Asthma	☐ Diabetes	☐ Bleeding disorders	☐ Excessive bruising
☐ Headaches	☐ Blood clots	☐ Heart related problems	☐ Smoking ____ per day

Please answer the following for any history of adverse reactions

Previous reaction to anaesthetics? **Yes** ☐ **No** ☐

Previous reaction to other medications? **Yes** ☐ **No** ☐

Allergies? **Yes** ☐ **No** ☐ If yes, please provide details

Previous severe reaction to adhesive tape, etc.? **Yes** ☐ **No** ☐

Previous reaction to antiseptic lotions or creams? **Yes** ☐ **No** ☐

Previous reaction to local anaesthetic agent? **Yes** ☐ **No** ☐

Please list your current medications (including blood thinning medications such as Aspirin, Warfarin or Clopidegrol as well as any over the counter medications such as Apririn or Glucosamine)

Please tick each box and initial once you have read and understood the below items.

Your privacy

In accordance with the Privacy Act (1988) all information collected in this practice is treated as sensitive information. To protect your privacy, this practice operates in accordance with the Act.

We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone number, etc.

Selected information may be disclosed to various other health services involved in supporting your health care management (e.g. pathology, radiology, hospital or specialists).

If you have any questions regarding the management of your personal health information or need to arrange to access your records, please ask reception staff or your doctor, as appropriate.

☐ _____

Patient consent to collect information

To ensure quality and continuity of patient care, a patient's health information may need to be shared with other health care providers/diagnostic facilities. Some information about patients is also provided to Medicare and private health funds, if relevant, for billing and medical rebate purposes.

I consent to images (still photographs or video) being taken for record keeping, therapeutic monitoring and education purposes.

☐ _____

Account conditions

Payment of a consultation account is due on the same day of service, for all other accounts, payment is due within 30 days of the date of the invoice. If any portion of the account should be overdue, then the full balance of the account will become due and payable on demand.

The patient agrees that if the account is not paid by the due date that the account may be lodged with a collection agent for recovery, and in such circumstances that the patient will bear an account surcharge of 25% to cover the agent's commissions. In the instance of legal action, the patient agrees to bear all legal costs and disbursements incurred in the recovery of the debt.

☐ _____

Medicare electronic claiming

I authorise this practice to lodge this claim electronically with Medicare and for Medicare to return, where necessary, updated Medicare details.

☐ _____

I _____ understand and consent to the above.

Your signature _____ Date _____