DERMATOLOGY WA

PATIENT DETAILS

(Dr, Mr, Mrs, Ms, Miss)

SURNAME: ………………………………………………

FIRST NAME: ………………………………………………………

ADDRESS…………………………………………………………………………

SUBURB……………………………POST CODE………………………………

POSTAL ADDRESS……………………………………………………………

……………………………………………………………………………………

EMAIL ADDRESS (please print clearly in **lower case**)

……………………………………………………………………

MEDICARE NUMBER ……………………………………………………………

INDIVIDUAL NUMBER ON CARD (I.E. 1/2/3/4 etc)………………………

DATE OF BIRTH:

DAY………..MONTH…………….YEAR…………………

TELEPHONE (H)……………….(MOBILE)……………………………………

Name of GP if not referring doctor………………………………………….

PRIVATE HEALTH INSURANCE Yes/No – **Fund Name**…………………

Department of Veterans' Affairs number if applicable

………………………………**(Gold,White or Blue)**

NAME /ADDRESS OF PERSON RESPONSIBLE FOR ACCOUNT IF DIFFERENT THAN ABOVE PATIENT INFORMATION

……………………………………………………………………………………

……………………………………………………………………………………

IS THIS A WORKERS COMPENSATION CLAIM? Yes No

Insurance Co………………………………Address……………………………

Claim No…………………………

I give permission for my Consultant Dermatologist to communicate with my General Practitioner and any other medical practitioner concerned with my skin condition in order to facilitate treatment.

SIGNATURE……………………………………DATE……../……../………