DERMATOLOGY WA

PATIENT DETAILS

(Miss, Master)

SURNAME: ……

FIRST NAME AND INITIAL: ……

DATE OF BIRTH:

DAY……MONTH……YEAR……

ADDRESS……

SUBURB……POST CODE……

POSTAL ADDRESS……

……

TELEPHONE (H)……(MOBILE)……

MEDICARE NUMBER ……EXPIRY DATE……/……

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

PRIVATE HEALTH INSURANCE Yes/No – **FUND NAME**……

Medicare requires one parent's full name and date of birth to enable the reception staff to transmit your child's invoice Online to Medicare.

FATHER OR MOTHER'S FULL NAME……

DOB:……

MEDICARE NUMBER ……EXPIRY DATE……/……

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

EMAIL ADDRESS:……

NAME OF GP……

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

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

SIGNATURE……DATE……/……/……