SOUTH EAST DERMATOLOGY

Annerley Square
9/461 Ipswich Road
Annerley QLD 4103

We accept correspondence
via Medical Objects

Contact
Ph: 07 3843 0577
Fax: 07 3398 2156
Email: info@sebderm.com.au
Web: www.sebderm.com.au
A.B.N. 86 709 735 814

PATIENT QUESTIONNAIRE

(

I Would Like to See (write Doctors name or next available if no preference:

Please be aware that there will be an out of pocket fee for your appointment and any resulting procedures including any pathology that may be required

Personal Details please complete and sign each page where marked

Title: **Surname:** **GivenNames:**

……..... ..... ……

☐ ☐ Date of birth / /
Male / Female (Please tick) ……. ……. ……

Residential Address: ……..…… **Suburb**: ..... **Postcode:** ……..…

Postal Address: (if different to above) ..……..……..……..…….

Phone Numbers: Home: ……..Work/Business hours: ……..……..

Mobile: .....

Email.....

Medicare Number: _ _ _ _ _ _ _ _ _ _ Family Number: _ (before your name) Expiry Date: _ _ /_ _ _ _

Veteran Affairs Number: …….....

- Pension/Health care card: Yes ☐ No ☐ If yes, please state type, card number and expiry date)

Pension Type: ..... Expiry: ……..... Card Number: ……..…...

- Aboriginal or Torres Strait Islander: ☐ Yes / ☐ No
- Please state other cultural background: ……..……..
- Occupation: ....…….....…… Employer: .....……..……..
- Is this visit related to Workers' Compensation? ☐ Yes / ☐ No (If yes, please state compensation number: .....…..……..)

Do you have a regular pharmacy for faxing or posting script ? ……

Describe in your own words the reason for your presentation to South East Dermatology: ……..……..

……...

……

……

Signature:

....
Date:

Please Turn Over

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Name of Referring Doctor: ………………………………..……..……... Address: ....

Suburb: .... Postcode: ……………..

Name of Usual G.P. ………………………………..............................…… Address: ....

Suburb: .... Postcode: ……………..

Contact Details

- What phone number can we call you on regarding results, recalls or to change an appointment: ………...………......…………
- Can we leave messages for you identifying the surgery as the caller ☐ Yes / ☐ No
- Do you wish to receive an SMS notifying you of your upcoming appointment **SMS Reminder:** ☐ Yes / ☐ No
- **Do you wish to receive results/correspondence via emails (if your doctor provides this option):** ☐ Yes / ☐ No

  E-Mail: ……………..………………..……………........…….…..

Emergency Contact

Name: …………………………………………..…………………………..………… Phone number: ……......……..…..………….…..…....

Address: ……........................……………………………………………….…. Relationship: ………………........……......................

Account Holder Person responsible for account (i.e. next of kin and/or legal guardian (if not yourself))

Name: …………………………………………..…………………………...……..... Phone number: ……………...……….……...………....

Address: ……........................…………………………………………………… Date of Birth: …..……/…………/…………

Medicare Number: _ _ _ _ _ _ _ _ _ _ _ Family Number: _ (before your name) Expiry Date: _ _ /_ _ _ _

Authorised Contact

I hereby authorise: .... Relationship: ....

Phone number: .... to obtain results on my behalf should I be unavailable.

Please consider the following before authorising others to make enquiries on your behalf regarding your medical care:

- Information supplied to the authorised person may be of a private or sensitive nature.
- It is your (the patients) responsibility to notify us of any changes to the authorised contact.
- In some circumstances information may not be given over the telephone and a face-to-face consultation maybe required. In this instance the need to make a further appointment may be relayed to your authorised contact.

Signature: .... **Date:** ………………

Please Turn Over

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Medical History

Do you have any medical conditions the doctor should be aware of? i.e. Asthma, diabetes, heart conditions etc. (please detail)

……

……

Do you have a history of problems with your skin? (please detail)

……

……

……

Have you been in contact with / or been diagnosed as having any of the following? (please circle)

- Hepatitis A / B / or C ☐ Yes / ☐ No
- HIV (AIDS) ☐ Yes / ☐ No
- Have you ever had a malignant melanoma? ☐ Yes / ☐ No
- Have you ever been a smoker? ☐ Yes / ☐ No When did you last have a cigarette? ...../...../.....
- Are you or could you be pregnant? ☐ Yes / ☐ No
- Do you have a family history of skin problems? ☐ Yes / ☐ No

Past Major Operations: (including heart valve, open heart surgery, joint replacement etc.)

…… ……

…… ……

…… ……

Current Medications: (please list)

…… ……

…… ……

…… ……

Are you allergic to Penicillin? ☐ Yes / ☐ No

Other Allergies (please detail)

……

……

Signature: **Date:**

……

Please Turn Over

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Privacy Consent Forms

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. 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. This means we will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. South East Dermatology may request photographs of your condition/s for the purposes of managing your skin conditions etc. Please note that in some circumstances the quality of care may be affected if photographs are not taken for monitoring purposes. All photographs are electronically stored and placed with the patient's file. For research purposes all photographs will be de-identified to ensure the privacy of the patient is maintained. This is a new process;all photos in the system prior to this consent form were upon verbal confirmation, please sign below to confirm the use of these photos. If you wish to review any of these photos or withdraw consent, please let us know.
4. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
5. Disclosure to other doctors in the practice, locums and by registrars attached to the practice for the purpose of patient care and teaching

In addition to providing consent to use information collected in these ways, I also give permission for my dermatologist to obtain medical information from other health professionals, if necessary.

If you have any questions in relation to any of the above matters please raise these with your doctor.

I have read the information above and understand the reasons why my information must be collected. I am also aware, following my discussions with my dermatologist and/or his/her staff, that the practice has a privacy policy on handling information. I have been offered the opportunity to review the practice privacy policy and have/have not reviewed the practice policy on handling patient information.

I understand that I am not obligated to provide any information requested of me, but that my failure to do so mightcompromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by South East Dermatology for the purposes set out above, subject to any limitations on access or disclosure that I have given notification of.

Print Name: _____ Signed: _____ Date _____

Print Name of Witness: _____ Signed: _____