NORTH SHORE ASSOCIATES IN DERMATOLOGY

Date_____

PATIENT DETAILS:

Title (Please Circle) Mr Mrs Miss Ms Mst Dr Other _____

Surname_____ First Name_____ Second Initial_____

Address_____

_____Post Code_____

Phone Numbers - Home_____ Work_____ Mob_____

Email _____

Date of Birth_____Occupation_____

Medicare No_____Position on Card_____ Expiry Date _____/_____

Dept of Veterans Affairs No_____ Gold Card / White Card

Pension Number (if applicable) _____ Expiry Date _____

GP (If different from referring doctor)_____

Address_____Post Code _____

This Practice does not bulk bill.

Payment at time of consultation is appreciated. Overdue accounts incur an administration fee of $10 + GST per month.

_____

Do you have a Pacemaker? (Please Circle) **Yes No**

Have you had heart valve or joint replacements? (Please Circle) **Yes No**

Are you taking any blood thinning medications? (Please Circle) **Yes No**

If Yes please circle Warfarin Aspirin Disprin Cartia Cardiprin Plavix Iscover Asasantin

What medications and/or creams are you using? _____

_____

_____

Do you have any ALLERGIES? (Please Circle) **Yes No**

Please List (eg Penicillin, Local Anaesthetic, Band-aids)

_____

_____