

New Patient Information Sheet



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|---|--------------------|------------|---|--------------------------------------|
| Mr /Mrs /Ms /Miss /Mast. | Given Name: | | Surname: | |
| Date of Birth: (DD/MM/YY) | ____/____/____ | | Postal address: (if different to residential) | |
| Residential address | Street: | | Street: | |
| | Suburb: | | Suburb: | |
| | State: | Post Code: | State: | Post Code: |
| Contact Phone | Mobile: | Home: | Work: | |
| Email Address: | | | | |
| MEDICARE # | | | Ref no: | Expiry: |
| VET. AFFAIRS FILE # | | Expiry: | Gold Card: <input type="checkbox"/> | White Card: <input type="checkbox"/> |
| Concession Card: Yes / No | Pension Card # | | | |
| Centrelink Health Care Card # | | | Expiry: | |
| Cultural Background: Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Other (Specify): _____. | | | | |

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|--|--|---------------------------------------|---------------------------------------|
| Next of Kin Name: _____ <i>(nominated person if you are unable to be contacted or in case of an emergency)</i> | | Relationship to you: | |
| Contact Phone # | Mobile: | Other: | |
| How did you hear about Tasmanian Skin Clinic? | | | |
| Doctor <input type="checkbox"/> | Friend/Family <input type="checkbox"/> | Past Patient <input type="checkbox"/> | Yellow Pages <input type="checkbox"/> |
| Website <input type="checkbox"/> | Newspaper <input type="checkbox"/> | Other <input type="checkbox"/> | |

OUR STANDARD FEES ARE AS FOLLOWS:

| | Full Fee | Pension/HCC Holder Fee | Medicare Rebate Applicable |
|--|-------------------|------------------------|----------------------------|
| Initial Consultation | \$150.00 | \$125.00 | Between \$37.05 - \$70.00 |
| Subsequent Consultation | \$110.00-\$150.00 | \$ 95.00 - \$125.00 | Between \$37.05 - \$70.00 |
| Surgical Theatre Fee | \$60.00 | \$ 50.00 | No Medicare Rebate |
| Surgical procedures attract an out of pocket gap fee of between \$100 - \$300 per procedure unless advised otherwise. | | | |

All consultations and surgical procedures attract a fee. We do not bulk bill. I have read the above fee information and am aware that I can request further information regarding out-of-pocket expenses from reception or my doctor at the time of consultation. **I understand that the out-of-pocket fee is not claimable through either Medicare or any Private Health fund.**

Doctors and staff of this practice are committed to protecting all your information as private and confidential. Information is only collected with your consent and staff at this practice abide by privacy laws.

I hereby acknowledge that all details are true and correct and consent to the collection of my personal information for medical purposes.

Signature:.....

Date:.....