SYDNEY MELANOMA DIAGNOSTIC CENTRE
PATIENT REGISTRATION FORM

Appointment with: ……..…….. **Date**: ……../……../…… **Time**: ……

Have you been to the Sydney Melanoma Diagnostic Centre before? **YES / NO**

Title: …… **Surname**: ……. **First Name**: ……...

Date of Birth: ……../……../……. **Male** □ **Female** □ **Country of Birth**: ……..……..……

Address: ……..……

Phone: Home ……..…….. **Mobile**: ……..…… **Work**: ……..……

Email: ……..……..……

Occupation:……..

Health Fund? **YES / NO** **Fund Name:** …….. **Membership No**: ……

Medicare Card No: ……**Ref** …… **Expiry Date**: ……../……../……

Pension Card No: …….. **Expiry Date**: ……/……/……..……

Health Care Card No: ……..…… **Expiry Date**: ……/……..……/……..……..

Person to notify in case of emergency:……..…… **Relationship**:……

Phone: Home ……..…….. **Mobile**: …… **Work**: ……..……

Address: ……...……

GP Details: Name: :…….…. **Ph**: ……

Referring Doctor: ……

I agree to accept responsibility for payment of my account : *(signature)* ……..……...

Medical Information

Have you had anything removed from your skin before? ……..……

Do you have a family history of melanoma? ……

In the sun do you: Burn: □ Tan: □ Both: □

Have you been badly sunburnt in childhood or teenage years? …….…… Any Blistering? ……..……

Do you have any significant medical problems? **Yes / No**, (If yes please specify) ……

.....……..…….....

Please list current medications: ……..

……..=

Do you take Aspirin regularly? **YES / NO** Do you smoke cigarettes? **YES / NO**

Allergies:……..……

Health authorities recommend that surgical staff should be aware if patients consider themselves to be at any increased risk of exposure to the HIV (AIDS) or Hepatitis viruses. Please indicate on the form or advise the doctor personally if you believe you may have been potentially exposed to these viruses.

- I believe **I am / am not** at risk of having been exposed to the HIV or Hepatitis viruses.