NORWEST SKIN CANCER CENTRE

Patient Registration

At Norwest Skin Cancer Centre we are committed to providing our patients with the best care, to do this it is essential that your medical records are up to date and accurate.

Please would you assist us by completing the following:

Surname		**Title:**	
First Name		**Middle Initial**	
Date of Birth			
Country of Birth		**Number of years living in Australia**	
Street Address			
Suburb and Post Code			
Home Phone			
Work Phone			
Mobile Phone			
Email			
Emergency Contact	**Name:** **Tel:** **Relationship:**		

Your usual General Practitioner:

In the interests of ensuring comprehensive health care, do you consent to this practice making available copies of pathology results to your usual General Practitioner?

☐ Yes (if yes please provide details below) ☐ No

(If you do not have a regular GP please leave blank)

Name of usual GP	**Dr**
Practice Name	
Street Address	
Suburb	

Do your have Private Hospital Cover: ☐ Yes (if yes please name of fund below) ☐ No

Reminder Systems:

Our practice provides our patients with reminders for your skin cancer check.

Do you wish to have annual reminders sent to you?

☐ Yes ☐ No

Please Turn Over ⇨

Office Use Only: Administration staff will complete this section - please present cards at reception

Medicare Number	Ref No:	**Expiry**	__ /__ / ____
DVA (gold/white)		**Expiry**	__ /__ / ____
Pension Number		**Expiry**	__ /__ / ____
Health Care Card		**Expiry**	__ /__ / ____

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Your Health History - Do you have or have you had? (please tick if applicable)

☐ Heart Disease (eg Heart attack, Bypass surgery) ☐ Heart Valve Disease
☐ Pacemaker ☐ High Blood Pressure ☐ Rheumatic Fever
☐ Diabetes ☐ Asthma
☐ Chronic illness _____
☐ Other _____
☐ Operations _____

Have you been diagnosed with HIV, Hepatitis B or Hepatitis C? ☐ Yes ☐ No

Do you have any allergies or are you sensitive to drugs or dressings:
☐ Yes (If yes please provide details below) ☐ No

_____

Current Medications (including over the counter medications and vitamins):

_____ _____ _____

_____ _____ _____

Do you take blood thinning medications? (eg warfarin, aspirin):
☐ Yes (If yes please provide details below) ☐ No

_____

Please tick if <u>you</u> have had any:
☐ Sun Spots
☐ BCC (Basal Cell Carcinoma)
☐ SCC (Squamous Cell Carcinoma)
☐ Melanoma

Have any of your <u>family</u> members had:
☐ Sun Spots
☐ BCC (Basal Cell Carcinoma)
☐ SCC (Squamous Cell Carcinoma)
☐ Melanoma

Occupational and recreational activities for sun exposure history: Enter details below	
Current Occupation:	
Past Occupation:	
Weekend Activities (eg golf)	
Solarium use	☐ Yes (If yes please provide details below) ☐ No

Signature: _____ Date: _____

How did you learn about our practice?

☐ GP referral ☐ Relative or friend recommended ☐ Street signage
☐ Yellow Pages ☐ Internet Search