Sunspot
Skin Cancer Clinic

FIRST NAME:	KNOWN AS:
SURNAME:	

TITLE: **Mr / Mrs / Miss / Ms / Dr** GENDER: **M** ☐ **F** ☐ DATE OF BIRTH: / /

ADDRESS:	
SUBURB:	POSTCODE:

CONTACT PHONE NUMERS:

HOME: ☐ MOBILE: ☐ WORK: ☐

ALLOW SMS REMINDERS: **Y** ☐ **N** ☐

EMAIL: ☐

MEDICARE NUMBER: ☐☐☐☐☐☐☐☐☐☐	REF NUMBER: ☐	EXPIRES: ☐
DEPT. VETERANS AFFAIRS NUMBER ☐		EXPIRES ☐
PENSION/CARE CARD: ☐	TYPE ☐	EXPIRES: ☐
PRIVATE HEALTH FUND: ☐		
MEMBERSHIP NO: ☐☐☐☐☐☐☐☐☐☐	IF EXCESS PLEASE ADVISE AMOUNT	$
USUAL GENERAL PRACTITIONER: ☐		
CLINIC: ☐		

WHERE DID YOU HEAR ABOUT SUNSPOT?

Friend/Family (Word of Mouth)	☐	Referred from GP	☐	Sunspot Brochure	☐
Internet (Google, Website)	☐	Signage out Front	☐		

Radio (which station)	☐	☐
Newspaper (which newspaper)	☐	☐
Other	☐	☐

PRIVACY POLICY

Due to changes in the privacy act we need to provide you with the opportunity to read our Practice Privacy Policy.

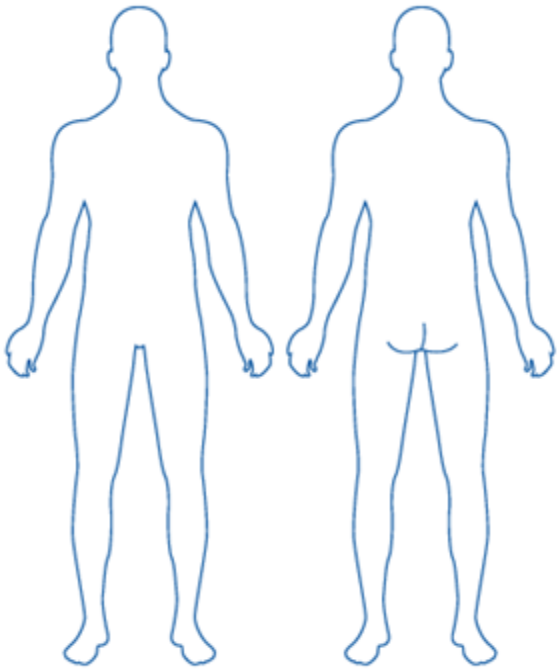
PERSONAL DECLARATION

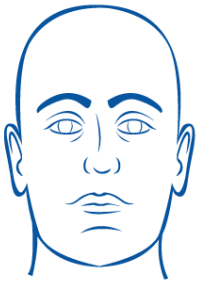
I have had an opportunity to read and understand the information contained in the Sunspot Skin Cancer Clinic Privacy Policy.

Signature: .....

Printed Name: ..... Date: .....

Please indicate with an X on the diagram any areas of concern.





Have you or any immediate family member been diagnosed with Melanoma? (Myself, Mother, Father, Sister, Brother or Child)	Yes		No	

Have you ever had anything cut off your skin?	Yes		No	
Location:		Diagnosis		

Have you ever had anything frozen or burnt off your skin?	Yes		No	
Location:		Diagnosis		

Any allergies to tapes or bandages?	Yes		No	

Any allergies to medications or injections?	Yes		No	
(If yes, list)				

Do you regularly take any blood thinning medications? (Aspirin, anti-inflammatory, herbal remedies for circulation)	Yes		No	

Do you have a pacemaker?	Yes		No	

List any regular medication