

URGENT CLINIC REGISTRATION FORM

PATIENT DETAILS

Mr Mrs Master Miss Ms Dr Prof Other

Surname: _____

Given Name: _____

Preferred Name: _____

Date of Birth: ____/____/____

Address: _____

Suburb: _____ Postcode: _____

Telephone Numbers:

Home: _____ Work: _____ Mobile: _____

Medicare Number: _____ Ref No: _____ Exp Date: _____

Private Health Insurance (Hospital Cover): Yes No

Private Health Fund Name: _____ Membership Number: _____

Concession Cards:

Aged or Disability Pension No: _____ Exp Date: _____

Dept. Veterans Affairs Card No: _____ White Gold Exp Date: _____

Health Care Card No: _____ Exp Date: _____

REFERRING DOCTOR DETAILS

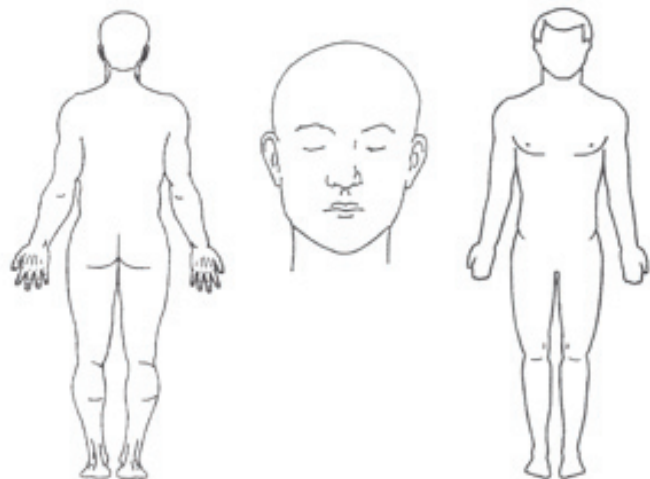
Name: _____ Provider number: _____

Practice details: _____

Reason for referral:

Please mark site(s)

- Suspected skin cancer
- Proven skin cancer
- Severe skin eruption
- Acute skin eruption
- Other, please specify:



Please fax this form to:

03 9038 4469