

Patient Registration Form

病人登记表

Title: Mr / Master / Miss / Mrs / Ms / Dr 称呼: 先生 / 男生 / 女生 / 太太 / 女士 / 医生

First Name 名字

Surname 姓氏 *As appears on Medicare card
*必须与Medicare卡上的名字一样

Preferred name 英文名字

Date of birth 生日日期

Address 地址

Postcode 邮编

Postal address: (if different from above) 邮寄地址 (如与以上地址不符)

Postcode 邮编

Contact Numbers 联系电话

Home 住宅

Mobile 手机

Work 工作

Email 邮箱

In case of emergency contact or NOK 紧急联系人

Name 名字

Relationship 与您的关系

Phone 电话号码

Medicare Card Number 卡号码

Number 卡号

Ref 编号 number to the left of your name
在您名字左边的数字

Expiry 有效日期

Department of Veteran Affairs (DVA) No. 退伍军人卡(DVA)卡

DVA card number (DVA)卡号

Colour 卡的颜色

Expiry 有效日期

Centrelink Health Care Card 医疗卡

Yes / No 持有 / 不持有

Card number 卡号

Expiry 有效日期

Are you on an Aged/Disability Pension

是否持有老年/残疾养老金卡? Yes / No 是 / 否

Card number 卡号

Expiry 有效日期

For children under the age of 18, please list the parent/guardian details or if someone other than the patient is paying for the account, please complete details for Medicare Claiming. 对于18岁以下的儿童, 请列出父母/监护人的详细资料。或者如果咨询费用不是患者本人支付, 请填写以下资料以便得到Medicare的索赔

First Name 名字

Surname 姓氏 *As appears on Medicare card
*必须与Medicare卡上的名字一样

Date of birth 生日日期

Medicare Card Number 卡号

Address 地址

Ref 编号

Postal address (if different from above) 邮寄地址 (如与以上地址不符)

Postcode 邮编

If your usual GP is NOT the referring doctor, and you would like us to send any correspondence/reports/ pathology to him/her, please list your usual GP's details. Please also list any other doctor(s) you would like us to send correspondence to: 如果您的家庭医生不是这次预约的推荐医生, 而您希望我们能将来往信件/报告/检验报告转告给他/她, 请在以下空格列出您家庭医生的详细信息。如您还有别的医生想被告知, 请一并列出:

Doctors name, clinic & address 医生名字/诊所名字和地址

Stay informed via email. Tick here to be on our cosmetic services mail list. 希望通过电子邮件等到诊所的最新资料, 请打勾加入我们医美的邮件列表



Follow us on Instagram
请在Instagram上关注我们
@melbourneeastsidermatology



Scan the QR Code and speak to us on WeChat
扫描二维码便可以在微信与我们联系

24 HOUR CANCELLATION POLICY 24小时取消预约政策

A \$100 cancellation fee applies for cancellations within 24 hours of the appointment time, or if you fail to attend without valid reason. Changing of appointments within 24 hours will require a deposit of the full consultation fee of your next appointment. The deposit is applied to your next appointment or can be refunded if the next appointment is cancelled at least 24 hours prior to the appointment time. By signing this form, you acknowledge that you have read and understood our cancellation policy. Please ask our reception staff if you require any further details on this policy.

如果您在预约前24小时以内取消, 或在没有正当理由的情况下缺席预约的话, 则需要支付\$100澳币的取消预约费用。如果您在预约前24小时以内更改预约的话, 您需要预付下一次预约的全额咨询费用。如果您在下次预约提前24小时取消预约, 预付的咨询费用可以被退还。通过签署此表格, 您确认您已阅读并理解我们的取消预约政策。如果您需要有关此政策的更多详细信息, 请咨询我们的前台。

PRIVACY POLICY 隐私条款

Consistent with our commitment to quality care, Melbourne Eastside Dermatology has developed a policy to protect patient privacy in compliance with privacy legislation. Your personal details and medical history (this may include photographic images of your skin condition) will be obtained. We take your privacy seriously. Further information on our privacy policy is available. Speak with our reception staff for a copy of our privacy policy.

与我们对您的优质服务和照料的承诺一样, 墨尔本东区皮肤专科诊所根据隐私法规制定了一项保护患者隐私的政策。您可以随时获得您的个人详细资料和病历 (包括您皮肤问题的图片)。我们尊重您的隐私, 如有需要请在前台获取隐私政策的副本。

FINANCIAL CONSENT 财务同意书

By signing this form, you consent to the private billing charges which you were informed of when booking your in-person or telehealth consultation. All accounts overdue for 60 days will be referred to our debt collection agency. In the event where your overdue account is referred to our collection agency and/or law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs.

通过签署此表格, 即表示您在预约面对面咨询或远程咨询时已被告知咨询的费用。所有逾期60天的账单都会自动转交给我们的收款公司/或律师事务所可能产生的费用将由持有账单的患者负责。

Signed _____

Date _____