laserdermatology
MEDICAL, SURGICAL & COSMETIC

PATIENT PACK
CONTACT DETAILS

LASER DERMATOLOGY

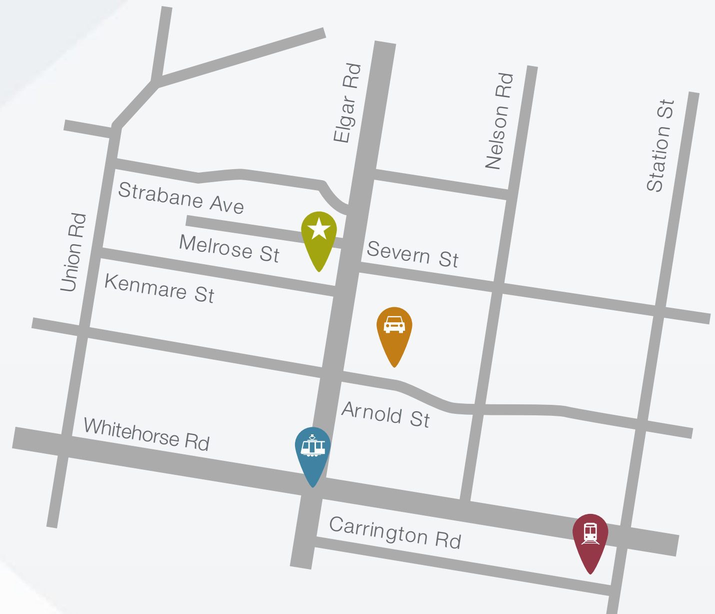
503 Elgar Road
Mont Albert North 3129 Victoria, Australia

+61 3 9890 1844
FREECALL: 1800-LASERS

HOURS OF OPERATION

- Mon - Fri: 9am - 5pm
- Sat: 9am - 1pm *
- Sun: Closed

* Hair & Tattoo appointments only



PUBLIC TRANSPORT

- Bus 612 - Box Hill to Camberwell
- Bus 202 - Box Hill to East Kew
- Tram 109 - Box Hill to Port Melbourne
- Train - Lilydale & Belgrave lines - Box Hill Station

IMPORTANT INFORMATION

- Appointment – please arrive 10 minutes prior to your appointment. Prior completion of your patient regisitration form (which can be found on the following page) will speed up the process.
- Referral – Please remember to bring your referral from your family doctor or referring specialist (tattoo and hair removal laser patients exempt).
- Where to park – there is limited on-site parking. We recommend parking in side streets or public carpark at the corner of Elgar Rd and Arnold St.
- Makeup – Please remember to remove makeup if you are having a consultation about or treatment on your face.
- Payment – Payments are to be made on the day of your appointment. Payment options include Visa, Mastercard, EFTPOS, and cash. Please note that large cosmetic treatments must be paid in full when making an appointment.
- Missed appointments – Failure to keep an appointment will incur a cancellation fee.

Please scroll down to view the patient registration form

Mr
Ms
Mrs
Miss .... Date of Birth ....
First Name Surname

Address .... Postcode ....

Home .... Bus .... Mob ....

Email ....

Pension .... (exp. date) .... Medicare No. .... (exp. date) ....

Occupation .... Employer ....

Person responsible for account ....

Address .... Bus .... A.H. ....
(If different from above)

Referring Dr. .... Address ....

Name of G.P. .... Address ....
(If different from above)

How did you find out about the clinic?

GENERAL HEALTH HISTORY

Have you suffered any serious illness in the past? ....

What operations have you had in the past? ....

Please indicate if you have a history of the following? ....

Allergies	....	Rheumatic fever	....	Heart trouble	....
Blood pressure	....	Fainting	....	Epilepsy	....
Kidney disease	....	Hepatitis	....	Diabetes	....
Lung disease	....	Blood clots, thrombosis	....	Bleeding tendency	....

Other ....

Are you at risk of developing HIV, Aids or Hepatitis? ....

Is there anything of a confidential nature you wish to discuss with the doctor / nurse?

....

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MEDICAL HISTORY

ALLERGIES

Are you allergic to any medicines, lotions or tape - please list

....

....

BLEEDING TENDENCY

Are you subject to prolonged bleeding or frequent nose bleeds?

....

....

CORTISONE

Have you ever been given cortisone or steroid tablets or injections? .... When? ....

MEDICATION

Please list any current medication (including herbal/alternative)

....

....

PATIENTS PLEASE NOTE – IF YOU HAVE BEEN REFERED BY ANOTHER DOCTOR

- Patients are advised that this practice does not bill Medicare direct for Patient Accounts
- G.P. referrals are valid for 12 months and Specialist referrals for only 3 months. Any patients attending without a current referral will still be charged the specialist rate but will be ineligible for Medicare rebate at the specialist level. Dr. Bekhor or his staff cannot request a backdated referral from your G.P. It is your responsibility to negotiate referrals from your doctor
- WorkCover and T.A.C. patients must provide correct details of the organisation accepting liability for payment of services including their employer, insurance company and claim number before treatment is undertaken
- You will be given your account after your consultation at which time settlement will be required. VISA / MASTERCARD and EFTPOS credit facilities are available

THE TERMS OF CONTRACT ARE SETTLEMENT OF ALL CONSULTATION ACCOUNTS ON THE SAME DAY.

Signed .... Date ....

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice including telephone confirmation of appointments
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice

This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.

- Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of patient care, teaching and research. Please let us know if you do not want your records accessed for these purposes and we will note your record accordingly

- I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information
- I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances
- I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained
- I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of

Signed .... Date ....

Witness ....