



skinsite

MOLE CHECKS
MOLE REMOVAL
SKIN DOCTORS

Registration Form

It would be helpful if you are able to complete this form prior to your appointment so that we can ensure we have your correct details.

Name _____	
DOB _____ Address _____ _____	Phone: Cell _____ Home _____ Work _____ Email _____
GP _____ Health Insurer _____ Membership number _____	Have you had melanoma or skin cancer? Y / N
Medications: _____ _____ _____ _____ _____	Medical Conditions: _____ _____ _____ _____ _____
Do you take a. aspirin Y / N b. warfarin Y / N	Do you have a. drug allergies e.g. penicillin/iodine Y / N (if yes, what?) _____ b. a cardiac pacemaker Y / N
Digital photography is extremely useful in detecting melanoma, monitoring skin treatments and teaching. Do you agree to any photos obtained being used for these objectives. Y / N	
Signed _____ Date _____	