



Neutral Bay
Laser & Dermatology
Clinic

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Dr Terence Poon

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Dermatologist
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Dr Marianne Nolan

BMed (Newc), MPH (Syd)

Dr Helena Torpinski

MBBS (Syd), FRACGP

Sr Kim Murphy

RN

Skin Laser Specialists

DATE: _____

NAME: _____ MR / MRS / MISS / MS / MSTR / DR

ADDRESS: _____

POSTCODE: _____

DOB: _____ EMAIL: _____

PHONE: Home: _____ Work: _____ Mobile: _____

MEDICARE NO: ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____

Valid To: _____ Ref No: _____ (The number in front of your name)

REFERRING DOCTOR – Please give receptionist your referral

**Payment is to be made on the day of your appointment.
We accept Visa/Mastercard, EFTPOS, cash or bank cheque only**

Please let us know how you found out about us: (tick one only)

- | | |
|---|---|
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Yellow Pages Online |
| <input type="checkbox"/> Dermatologist/Specialist | <input type="checkbox"/> Local Newspaper |
| <input type="checkbox"/> Friend/Family | <input type="checkbox"/> Television |
| <input type="checkbox"/> Internet Search | <input type="checkbox"/> Defence Forces (Army/Navy) |
| <input type="checkbox"/> Website | <input type="checkbox"/> Other – please specify |
| <input type="checkbox"/> Social Media | _____ |

THANK YOU