Patient registration form

Please fill in this form to help us provide you with the best possible treatment.
This information will be kept confidential to protect your privacy.

Title: Mr Mrs Ms Miss Dr

First Name | Last Name

Address | Postcode

Postal Address | Postcode

Phone: Home | Work | Mobile

DOB | Email

Person Responsible for Account: Self Veteran's Affairs Workcover Other | Name

Address for Account | Postcode

Next of Kin | Relationship | Phone

Medicare No | Ref No | Expiration Date MM / YY

Health Fund Name | Membership No.

Do you have a Pension Card? Yes No | Card No. | Exp Date MM / YY

Veteran's Affairs Number | Colour of DVA Card

If Third Party or Work Cover: Claim No. | Date of Accident / Injury DD / MM / YY

Insurance Company

Employer / Contact | Employer Phone

Employer Address

Referring Doctor

Name & Address of Family Doctor (if different)

MEDICAL HISTORY

Allergies

Pre existing medical conditions (eg. Heart Disease / High Blood Pressure / Lung Disease / Asthma / Diabetes / Blood Clots / Bleeding Disorder / Stomach Ulcers / Other)

Medications: (Regular or Herbal)

Do you smoke? Yes No If so, how many?

NOTICE ABOUT FEES

The cost of the consultation is above the Medicare Schedule of Fees is payable on the day. This means there will be an out of pocket after claiming from Medicare. Additional services on the day may incur further charges. Third Party, WorkCover, DVA and other compensable accounts will be sent according to the details provided. If there are no details, or the account is rejected by the external party, the account will become the responsibility of the patient. Should the account extend beyond our trading terms of 30 days and involve an outside collection agency, you will be responsible for their extra charges.

I have read the above, and agree to abide by the payment terms of this practice:

Signature | Date DD / MM / YY