Patient registration form

Note: Please fill out the form with your full legal name, sign it, and date it.
This will 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

- I consent to the use of my email address for all clinical and billing correspondence. ☐
- I consent to receiving text messages to confirm my appointment. ☐

Person responsible for account Self ☐ Veterans Affairs ☐ Workcover ☐
Other ☐ Name

Address for account | Postcode

Next of kin | Relationship | Phone

Medicare no | Ref No | Expiration date

Health fund name | Membership no.

Do you have a pension card? Yes ☐ No ☐ Card no. Expiration date

Veterans affairs number | Colour of DVA card

If third party of work cover: Claim no. | Date of accident/injury
Insurance company

Referring doctor

Name & address of family doctor (if different)

How did you hear about us? Word of mouth ☐ Referral ☐ Social media ☐
Google search ☐ Others (please specify)

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 yes, how often?

Notice about fees

The cost of the consultation is above the Medicare Schedule of Fees and 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.

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

Signature | **Date**