

PATIENT REGISTRATION FORM

Title Miss/Mrs/Ms DOB/...../.....
First Name.....
Surname..... Phone (H)
Middle Name..... Mobile.....
Known As..... Work.....
Occupation..... Email.....

Address.....
..... Postcode.....

Medicare number ____ _ ____ _ ____ _ Ref no ____ (number next to *your* name)
Expiry date ____/____

Private Health insurance Y / N Fund..... Hosp Extras only
Member no.....
HCC/Pension/DVA.....

Referring Doctor.....
Usual GP
Do you have any allergies? Eg drugs, tapes etc No/Yes.....
Next of Kin.....
relationship..... Phone
Partner's name.....

How did you hear about us?

This is a private specialist practice and there is an out-of-pocket cost for consultations.
Accounts are payable on the day of consultation. We accept payment by cash, cheque, credit card or EFTPOS.
We use a debt recovery service for overdue accounts, which will incur additional costs.
Additional fees incurred from referrals to pathology, ultrasound or other services are separate to our fees, and remain the responsibility of the patient.

The practice has policies with regards to privacy and health information. It may be necessary to share personal or medical information with other practitioners who are involved in your care. This is in accordance to the *Health Records Act (Vic) 2001* and the *National Privacy Principles* in the *Privacy Act (Cwth 1998)*. Please ask to see our Privacy Policy at reception for further information.

I acknowledge the above financial and privacy statements:

Signed:..... Date...../...../.....