NEW PATIENT REGISTRATION FORM

SURNAME (Mr/Mrs/Miss/Ms/Dr).....

GIVEN NAMES (As written on your Medicare Card).....

DATE OF BIRTH ...../...../.....

HOME ADDRESS.....

TEL HOME.....MOBILE.....WORK.....

NEXT OF KIN & CONTACT NO.....

MEDICARE No._____ REF No._____

MEDICARE CARD EXPIRY DATE.....

PENSION/HEALTH CARE CARD/DVA (Please circle) NUMBER.....

PRIVATE HEALTH FUND.....MEMBERSHIP #.....

WORKCOVER: Claim No.....Contact.....

LOCAL/FAMILY GP.....TEL.....

ADDRESS:.....

DISCLOSURE CONSENT:

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs.

I consent to the disclosure to medical/allied health practitioners and organisations who may require information about my medical history, but only to the extent necessary to assess/treat the particular condition that I have consulted my surgeon about.

I can retract this consent at any time upon written advice to my surgeon.

FINANCIAL CONSENT:

I have been informed of the fee payable for my consultation today. I understand that the full amount must be settled by the conclusion of the consultation. If there are any queries regarding the fee payable, please discuss with the receptionist/practice manager prior to entering the consultation. In the event where your overdue account is referred to a collection agency and/or law firm, you will be liable for all costs which would be incurred as if the debt is collected in full, including legal demand costs.

I agree to the above DISCLOSURE CONSENT and FINANCIAL CONSENT.

Signed……..... Date:

Patient Name:

YOUR SURGEON: