

Patient Registration

Please check and complete the following details

Ref No 0 (Staff use only)

Title _____ First names _____ Last name _____

Home phone _____ Work phone _____ DOB _____

Mobile phone _____ Opt out of SMS Messaging

Home Mobile

If we need to contact you and leave a message, may we use your Work Email

Email address _____

Street address _____

Postal address _____

Next of kin & Relationship _____ Phone _____

Address _____

Treatment area _____

Family Doctor
(Name & address) _____

Physiotherapist
(Name & Address) _____

Occupation _____

Private Health Fund _____ Membership number _____

Medicare _____ Ref No _____ Expiry _____ Veterans _____

Insurer _____

Are you making a claim for compensation? Date of injury _____

Workers' Compensation Claim Number _____

CTP _____

Personal Injury Claim Address _____

Public Liability _____

Sports Insurance Phone _____

Declaration

I have read the Privacy Amendment Act and give permission for correspondence to be sent to my referring doctor, general practitioner, physiotherapist and insurance company where appropriate.

I undertake to pay all fees owing to my Surgeon, including in the event that liability is denied or any outstanding accounts that have not been paid in full by my insurer.

I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery fees and I will also be responsible for any legal costs incurred.

Signed by patient or parent/guardian _____ Date _____