PATIENT REGISTRATION FORM

Today's Date _____

Please note that full payment is required on the day of your initial and any subsequent consultations. As Medicare does not completely cover the cost of your consultation, the gap payment becomes your responsibility.

PERSONAL DETAILS Title: Mr / Mrs / Ms / Miss / Master / Doctor / Other _____

Family Name: _____

Given Names: _____

Date of Birth: _____Age: _____ Country of Birth _____

Gender: □ Female □ Male Religion: _____

Marital Status (Single/ Married/ Widowed/ Divorced/ Separated/ DeFacto) _____

Postal Address: _____

State: _____ Postcode: _____ Email Address: _____

Would you like to receive correspondence regarding your surgery via email? _____
(Your information will not be shared for any advertising and marketing purposes)

Telephone (home) _____ Business/mobile_____

Would you like to receive SMS appointment reminders?_____ (This will not be used for marketing purposes)

Occupation: _____

Referring doctor:_____

Name of your usual GP and clinic: _____

How did you hear about Dr Woods? _____

Next of Kin: _____ Relationship _____ Telephone_____

MEDICARE / HEALTH FUND DETAILS

Medicare Number: _____ Ref No: _____ Expiry Date: _____

Do you have Private Hospital cover?_____

Health Fund Name: _____

Membership Number: _____Type of Cover:_____

Do you have an aged pension card? Yes/No Card No: _____

DEPARTMENT OF VETERANS AFFAIRS (IF APPLICABLE)

Department of Veteran's Affairs Card Number: _____ □ Gold card □ White Card

DECLARATION I _____
Certify that to the best of my knowledge and belief, the particulars set out on this form are correct. I am aware of the conditions relating to the payment of my account. I agree to my personal information being included in Central Day Surgery quality assurance and clinical audit activities .

Patient or Guardian's Signature:_____ Date: _____