NEW PATIENT REGISTRATION

South West Surgical

CONTACT INFORMATION

Title: _____ Given Names: _____ Surname: _____
Preferred Name: _____ Gender: M F Other Date of Birth:___/___/_____
Address: _____ P/Code: _____
Home Phone: _____ Work Phone: _____
Mobile No: __ __ __ __ __ __ __ __ __ __ Email: _____

CARD DETAILS

MEDICARE: __ __ __ __ __ __ __ __ __ __ __ Number next to name: ____ EXP: _____/_____
PENSION CARD NO: _____ EXP: ___/_____/___
HEALTH CARE CARD NO: _____ EXP: ___/_____/___
DEPARTMENT OF VETERAN AFFAIRS NO: _____ Gold/White

DO YOU HAVE PRIVATE HEALTH HOSPITAL COVER? YES ❑ NO ❑
Name of Fund: _____ Membership No: _____

IS THIS A WORKCOVER/TAC claim YES ❑ NO ❑ CLAIM NO: _____
Employer Name: _____ Phone No: _____
Insurer Name: _____ Phone No: _____

WHO IS YOU USUAL DOCTOR

Doctor/GP: _____
Clinic: _____

EMERGENCY CONTACT –

Name: _____
Relationship to you: _____ Phone No: _____
Is this contact your legal Medical Decision Maker or Power of Attorney? YES ❑ NO ❑

PATIENT CONSENT:

Fees: I understand that I am financially responsible for any fees charged.
Privacy: This practice collects and discloses information for the primary purpose of providing quality health care. I give consent to this practice accessing health information including pathology, radiology, surgical and other medical information which will solely be used for health care purposes.

Information may be required to be disclosed or collected to/from others involved in your care including doctors/specialists/hospitals outside this practice. This may occur through referral to other doctors for medical tests and reports or results referred to us. At all times we are required to ensure your details are treated with the utmost confidentiality. The privacy policy of the practice ensures appropriate management of all patient information that is collected/transmitted via electronic fax, post and email.

I understand & consent to the above YES ❑ NO ❑

SIGNATURE: _____ DATE ___/____/_____
Name of Carer/Guardian (if applicable) _____