Patient Registration

Date		
Patient details		
Title	First name	Surname
Preferred name		Pronoun
Address		
	State	Post code
Date of birth		
Telephone numbers		
Email address		
Person to contact in an emergency		
Relationship to you		Contact number
Can we disclose medical information to this person?		Yes/No
Signature		

Private Health Insurance and Medicare details	
Private Health Insurance	Yes/No
Company	Membership no
Medicare number	Expiry
Medicare reference – *number before your name*	
Referring doctor	
How did you/your doctor hear about us?	

Disclosure Statement – *our full privacy policy is available on request*

I DO / DO NOT give permission for my medical details and results to be given to my referring doctor or to other doctors and health professionals including the admitting hospital involved in my care.

Signature

Please notify staff as soon as possible of any changes to your contact details, GP, next of kin or Medicare card.