Patient Registration Form

|  |
| --- |
| **Patient Information:** |
| Title (circle): Mr Mrs Miss Ms Dr MX |
| Patient Name: |
| Address: |
| Date of Birth: |
| Phone: Mobile: SMS reminders: Yes / No |
| Email: |
| Are we able to leave a confidential message for you regarding results, recalls, confirming, changing or cancelling appointment? Home Phone: Yes / No Work: Yes / No Mobile: Yes / No |

|  |
| --- |
| **Medicare Details:** |
|  |
| **Medicare number:** Ref: Expiry: |
| Pension / Health Care Card number: |
| Veteran Affairs number: Expiry: Gold / White |
|  |
| Private Health Fund: |
| Membership number: Reference number: |
| Date commenced: |

|  |
| --- |
| **Next of Kin / Emergency Contact:**  |
|  |
| Name: |
| Address: |
| Phone: Mobile: |
| Relationship: |

|  |
| --- |
| **Referring Doctor:** |
|  |
| Name: |
| Address: |
| Phone: |
| Is this your usual GP? (circle) Yes / No |
| If no, Name of GP? |
| Name: |
| Address: |
| Phone |

|  |
| --- |
| **Privacy** |
| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_consent to the release /access by One Heart Cardiology staff of my medical record to any health service provider that requires the information for the purpose of treatment or audit of my current, past or future conditions.Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ |