

New Patient Registration

Please complete all relevant sections



Hand
SURGERY CENTRE

Personal Details:

Title: (Mr Mrs Ms Miss Master Dr) Other: _____

First Names: _____

Surname: _____

Address: _____

Postal Address if different: _____

Date Of Birth: _____

Phone: H) _____ W) _____ M) _____

Email Address: _____

Your Occupation: _____

Next of Kin Name: _____ Phone: _____

Membership Card Details:

Medicare Card Number: _____ Ref: Number next to your name: __

Private Health Fund: _____ Member No: _____

Veterans Affairs No: _____ Card Colour: _____

Pension of HCC No: _____ Expiry: _____

Referring Details:

Family Doctor (GP) Name: _____

Family Doctor (GP) Address: _____

Referring Doctor (If different from GP): _____

Account Holder if patient is a minor (age 0-17):

Name: _____ Date Of Birth: _____

Your Medicare Card Number: _____ Ref: Number next to your name: __

Once form is complete please sign below and the two attached privacy consent forms

Signed: _____ Date: _____

***Workcover/Third Party patients please turn the page

Workers Compensation / Third Party

Please complete ALL Sections

* Marked on mandatory fields



Claim Details:

* Date Of Injury: __ __ / __ __ / __ __ __ __

Injury: _____

Is your injury a result of a Motor Vehicle Accident? Yes / No

Insurance Company Details

* Insurance Company: _____

* Claim Number: _____

Address: _____

Claims Manager Name: _____

Claims Manager Phone: _____

Claims Manager Email: _____

Contact Fax Number: _____

Work Details:

* Company Name: _____

Contact Number: _____

Address: _____

I _____ have provided the information to the best of my knowledge and understand that I will be personally responsible for the payment of all medical fees should the cost not be met by my insurer.

Signed: _____ Date: _____