

New Patient Registration



Hand
SURGERY CENTRE

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

First Name: _____

Middle Name: _____

Surname: _____

Preferred Name: _____

Address: _____

Postal Address if different: _____

Date Of Birth: _____

Phone: H) _____ W) _____ M) _____

Email Address: _____

Your Occupation: _____

Next of Kin Name: _____ Phone: _____

Relationship to You: _____

Membership Card Details:

Medicare Card Number: _____ Ref (next to your name): _Exp_____

Private Health Fund: _____ Member No: _____

Veterans Affairs No: _____ Card Colour: _____ Exp_____

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: _____

Medicare Card Number: _____ Ref (next to your name:) _Exp_____

Once form is complete please sign below acknowledging you have completed the form with correct information and also read and sign two attached privacy consent forms

Signed: _____ Date: _____

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: _____

* Claim Manager Name: _____

* Claim Manager Phone: _____

* Contact Fax Number: _____

* Claims Manager Email: _____

Work Details:

* Company Name: _____

* Address: _____

* Contact Number: _____

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: _____