Malvern Hill Consulting

New Patient Registration Form

Patient Information

Title: • Mr • Mrs • Miss • Ms • Master • Other _____ Date of Birth: _____/_____/_____

Surname: _____ Given Name(s): _____

Address: _____ Suburb: _____ Postcode: _____

Mobile: _____ Home: _____ Work: _____

Email: _____ Occupation: _____

Usual General Practitioner (If not referring doctor): _____

GP Address/Clinic: _____

Next of Kin Name: _____ Contact number: _____

Relationship to Patient: _____ Consent to Contact in an Emergency: • Yes • No

Medicare Details

Patient Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref Number: _____

Account Holder if patient is under 18 years of age:

Parent/Guardian Full Name: _____ Parent Date of Birth: _____

Parent/Guardian Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref Number: _____

Private Health Insurance Details

Private Health Fund: _____ Membership Number: _____

Do you have hospital cover with your private health fund? • Yes • No
Have you had hospital cover with your health fund for longer than 12 months? • Yes • No

If less than 12 months, please specify the month and year you joined your health fund: _____

Concession Card/ Work Cover Details

Aged or Disability Pension No: _____ Expiry date:_____

Dept. Veterans Affairs Card No: _____ Expiry date:_____

Dept. Veterans Affairs Card Colour: • White • Gold

Health Care Card No: _____ Expiry date:_____

If you are a Workcover or TAC patient, please provide claim number: _____

Fee Policy/ Privacy Statement

Fee Policy: All consultation fees are to be paid on the day of consultation. Malvern Hill Consulting does not routinely bulk bill consultations. A valid DVA, TAC or other form of approved Work Cover is accepted. The costs for any surgical out of pocket expenses will be discussed with reception following your consultation. Failure to attend a booked appointment, without prior notification, will incur a cancellation fee.

Privacy Statement: We require you to provide us with your personal details and medical history so that we may properly diagnose, treat and be proactive in managing your health care needs. This practice handles personal information in accordance with the Victorian Health Records Act and the Commonwealth Privacy Act.

I consent to the handling of my information by this practice for the purpose of providing quality health care, associated administrative and billing purposes. I give permission for medical information to be obtained from any other source, in order to help with my treatment and to be disclosed to others involved in my health care, including treating doctors and specialists outside this medical practice as advised by you.

I understand that despite all appropriate precautions being taken, protection of my personal information cannot be guaranteed.

I have read the above fee policy and privacy statement, and consent to the taking and use of my medical records as described, and I agree to pay the costs of consultations and any surgical procedures performed.

Name: _____ Signature: _____ Date: ___/____/_____