melbourne kidney specialists
melbournekidneyspecialists.com.au

PATIENT REGISTRATION FORM

Title: (Mr Mrs Ms Miss)		**Gender**: Male / Female
Given Name:	**Middle Name:**	
Surname:		
Preferred title/name:		**Date of birth:**
Telephone:	**Work:**	**Mobile:**
Email:		
Street:		
Suburb/City:		**Postcode:**
EMERGENCY CONTACT **Name:** **Relationship:**	**Telephone**:	

Is English your first language? ☐ Yes ☐ No

If no, please indicate if an interpreter is required. ☐ Yes ☐ No

Please indicate language:

ACCOUNT DETAILS

Medicare Card

Card number: ___________________________________ Ref no: _______

Expiry: ________________

Concession Pension, Health Care Card ☐ Yes ☐ No

If yes, which card - Pension Health Care Card? *(please circle)*

CRN: _____-_____-______ Expiry: ____/____/______

Private hospital insurance ☐ Yes ☐ No

If yes, Health Fund Name: __________________________

Membership No: ____________________________

Veteran Affairs Card (DVA) ☐ Yes ☐ No

If yes, Card Colour: Gold/White? *(please circle)*

DVA No: ___________________

WorkCover ☐ Yes ☐ No

Claim No: ______________________ Date of Injury: _________________

Name and Address of Insurance Company:

____

____

WorkCover (continued)
Case Manager: ____
Phone: _________________________Fax: _______________________
Employer Name and Address:
____
_______________________________________Phone: _____________

TAC
Claim No: _____________________ Date of Injury: ________________ ☐ Yes ☐ No

What method of communication/s can we contact you regarding results, recalls or to change an appointment? *(please circle)*
Telephone/Work/Mobile/Email

Would you like to be contacted via SMS (mobile text message) for: appointment reminders, recall reminders or messages? ☐ Yes ☐ No

My Health Record:
Do you give consent for our doctor to access your *My Health Record*? ☐ Yes ☐ No

Referring Doctor:	
Address:	**Phone:**
	Fax:
General Practitioner/GP:	
Address:	**Phone:**
	Fax

I authorise the following person to take messages regarding a recall, reminder or change of appointment – ***optional only***

Name:	
Relationship:	Telephone:
Signature to authorise the above:	

Consent
I understand that Melbourne Kidney Specialists complies with the Privacy Act (1988) and as part of their Privacy Policy, they are committed to protecting the privacy of individuals and their personal information. The purpose for collecting my personal information is to provide quality medical and health related services and associated account keeping. Melbourne Kidney Specialists makes every effort to manage my information in accordance with the National Privacy Principles and keep my records accurate and up to date. My signature below indicates that I have read the above and consent to the following: collecting, using, storing and disposing of my personal information and releasing relevant personal information to other health professionals to allow quality medical care e.g. specialists and pathologist.
We will use the listed contact methods above if we need to communicate with you. If you do not wish to for us to use any of these methods, please let our receptionist know.

Signed: ____**Date:** ____/____/______