

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:
<u>EMERGENCY CONTACT</u>		
Name:		
Relationship:	Telephone:	

LANGUAGE

Is English your first language? Yes / No *(Please circle)*

If no, please indicate if an interpreter is required. Yes / No *(Please circle)*

Please indicate language: _____

ACCOUNT DETAILS

Medicare Card

Card number: _____ Ref no: _____

Expiry: _____

Concession Pension, Health Care Card

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

Yes No

CRN: ____ - ____ - ____ Expiry: ____ / ____ / ____

Private hospital insurance

If yes, Health Fund Name: _____

Membership No: _____

Yes No

Veteran Affairs Card (DVA)

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

Yes No

DVA No: _____

WorkCover

Claim No: _____ Date of Injury: _____

Yes No

Name and Address of Insurance Company:

WorkCover (continued)	
Case Manager: _____	
Phone: _____	Fax: _____
Employer Name and Address: _____ _____ Phone: _____	
TAC	
Claim No: _____	Date of Injury: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
What method of communication/s can we contact you regarding results, recalls or to change an appointment? <i>(please circle)</i> Telephone/Work/Mobile/Email	
Would you like to be contacted via SMS (mobile text message) for: appointment reminders, recall reminders or messages? <input type="checkbox"/> Yes <input type="checkbox"/> No	
My Health Record: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you give consent for our doctor to access your <i>My Health Record</i> ?	

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:** ____/____/____