DRSCOTTPEARCE

PATIENT REGISTRATION

It is important that you complete all sections of this registration form. Please inform the receptionist if you are unable to do so

(MRS/MS/MISS/MR/DR) GIVEN NAME: …….. MAIDEN NAME:……..……..…..

SURNAME: …… ADDRESS: ……..…..

…….. SUBURB:…….. POST CODE: ……

PHONE: (Home)……(Work)……..…..(Mob)…….EMAIL:……..…..

DATE OF BIRTH: ……/……/……. MEDICARE NO: _ _ _ _ _ _ _ _ _ _ EXP DATE: ……. REF NO: ……

PRIVATE HEALTH FUND: …….. MEMBERSHIP NO:……..……

Have you held hospital cover longer than 12 months? YES / NO or UNINSURED (please circle)

MARITAL STATUS: …….. YOUR USUAL GP: ……..…..

REFERRAL SOURCE: Dr Family Friend MIVF Other: …… YOUR OCCUPATION: ……..
(Please circle)

NEXT OF KIN/PARTNER: ……..…….. DATE OF BIRTH:……/……/…….

PHONE: (Home)……(Work)……..…..(Mob)…….EMAIL: ……..…..

RELATIONSHIP: …… OCCUPATION: ……..…..

EMERGENCY CONTACT (other than Next of Kin)……..……..……

PHONE: (Home)……(Work)……..…..(Mob)…….RELATIONSHIP:……..…..

GENERAL HEALTH:

MEDICATIONS…… **ALLERGIES**……

Do you currently have, or have you suffered from the following:

- ❑ **Heart problems**
- ❑ **High Blood Pressure**
- ❑ **Lung problems**
- ❑ **Urinary or Bladder problems**
- ❑ **Stroke**
- ❑ **Thrombosis, clotting or DVT**
- ❑ **Diabetes**
- ❑ **Epilepsy**
- ❑ **Stomach or bowel problems**
- ❑ **Thyroid problems**
- ❑ **Hepatitis or H.I.V.**
- ❑ **Anaemia**
- ❑ **Depression**
- ❑ **Psychiatric problems**
- ❑ **Other……..……**

TOBACCO (how many?)…… ALCOHOL (HOW MUCH?)……..

PRIVACY STATEMENT:
This medical practice collects information from you for the primary purpose of providing quality healthcare. We ask you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare needs. We may use the information you provide for administrative purposes in running our medical practice, including billing and compliance with Medicare and Health Insurance Commission requirements. Information may be sent to other practitioners involved in your care. Confidentiality will always be maintained if any information related to your care is used in research, quality assurance or educational purposes.

PAYMENT PROCEDURES:
Please advise the receptionist if you are unable to pay your account at the time of consultation. Patients who do not pay their account after consultation are advised that the payment is due within 14 days. **Accounts not paid within 14 days will incur a late fee.** This practice uses a Debt Recovery service for overdue accounts. **Any charges incurred for this service will be passed on to the patient.** We understand you may need to cancel your scheduled appointment, please notify us as soon as possible, **however if an appointment is missed or cancelled without 1 business days' notice a fee of $105** will be incurred.

I consent to the handling of my information by this practice for the purpose set out above.
I understand my obligation with regard to payment of my account.

Signed:……..……..Date:……