



Member Details

About You

Title Mrs [] Ms [] Miss [] Mr [] Dr [] Other _____

Given Name _____

Surname _____

Known as _____

Date of birth _____

Medicare No _____

Ref No _____ [Next to name on card] Expiry date _____

Person Responsible for accounts Self [] Other [] [If other, please provide name and address]

Name _____

Address _____

If you hold a Government issued concession card, Dept of Veteran Affairs card (white or gold) or Government issued health care card, please provide details

Entitlement number _____ Expiry date _____

Contact Details

Street no and name _____

Suburb _____ State _____ Postcode _____

Tel Home _____ Tel Work _____

Mobile _____ Fax _____

Email Address _____

Next of kin _____ Relationship to you _____

Phone _____

We can arrange your Medicare refund for you. To receive the rebate electronically within 48 hrs, your bank details need to be recorded with Medicare. If you haven't previously done this we can do this for you.

Account Name _____

BSB _____

Account Number _____

Financial Institution & Branch _____

About You

The following questions are optional. However, the information you provide will help us develop programs and services that meet our patients requirements, both now and into the future. Please be assured that all information you provide will be kept strictly confidential.

How did you hear about us? Another Doctor [] One of our patients [] A chemist []
Cinema advertising [] Yellow Pages [] Our website []
Google [] Our sign [] Other [] _____

Preferred time to see the doctor (normally) **Day** Mon [] Tue [] Wed [] Thu [] Fri [] Sat [] Sun []

Time of Day
7.30 am to 9.00 am []
9.00 am to 12.00pm []
12.00 pm to 2.00 pm []
2.00 pm to 5.00 pm []
5.00 pm to 7.00 pm []
After 7.00 pm []

Additional Services Would you be interested if we offered online services such as a booking system, access to test results and a service to request scripts and referrals?

Yes [] No []

About Your Information

The personal information you provide during your consultation and subsequent treatment will be collected for the sole purpose of providing high quality healthcare. This practice is committed to protecting your privacy and this information is only disclosed to other member of your treating team where medically necessary. It may however be disclosed to other organisations where required by law. Information on this form alone may be used for debt recovery purposes if necessary. You may access the information held about you by contacting the practice on 9908 2233.

Signature _____ Date _____