WOMANKIND HEALTH

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NEW PATIENT REGISTRATION

Please take a few minutes to complete the following details for our records
Should any of your details change please notify us as soon as practicable.

TITLE ..... **SURNAME**.....

GIVEN NAMES ..... **PREFERRED NAMES** .....

Do you identify as? ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

DATE OF BIRTH ..... **GENDER** ..... **PRONOUNS** .....

ADDRESS ..... **HEIGHT** ..... **WEIGHT** .....

SUBURB ..... **POSTCODE** ..... **STATE** .....

POSTAL ADDRESS As Above ☐ .....

PHONE (MOBILE) Is this your preferred contact? Y ☐ **PHONE (HOME)** Is this your preferred contact? Y ☐

....

EMAIL ADDRESS .....

MEDICARE NUMBER _ _ _ _ _ _ _ _ _ _ **REF** _ **VALID TO** _ _ / _ _ _ _

Do you have private hospital cover? YES / NO **Obstetric cover?** YES / NO

FUND ..... MEMBER NUMBER: .....

REFERENCE NUMBER: .....

Do you have an aged pension or disability pension? CIRCLE TYPE IF YES

CARD NUMBER :..... EXPIRY:.....

Occupation: ..... Do you consent for upload to My Health Record? YES / NO

EMERGENCY CONTACT INFORMATION/ RELATIONSHIP TO YOU ..... **Next of Kin?** ☐

Name ..... Phone.....

Referring Doctor ..... Clinic .....

Medicare or Health Funds do not completely cover the cost of your consultation or treatment. We endeavour to keep patients out of pocket fees at a reasonable price. We ask, where possible, that you pay your consultation account in full on the day. With your consent, we will transmit the claim to Medicare as soon as practicable so your entitled Medicare payment can be reimbursed to you.

Some procedures will incur additional costs. A quotation can be arranged for you in advance upon request. This information is true and accurate. I understand that I am responsible for the payment of accounts. My details are current and correct with Medicare Australia and I authorise transmission of claims on my behalf to Medicare and where required, agree to the assignment of the medicare benefit directly to the health professional.

Signed ..... Date .....…