# Patient Registration

**Please check and complete the following details** Ref No (Staff use only)

Title First names Last name

Home phone Work phone DOB

Mobile phone ☐ Opt out of SMS Messaging

Email address

Street address

Postal address

Next of kin & Relationship Phone

Address

Treatment area

Family Doctor (Name & address)

Physiotherapist (Name & Address)

Occupation

Private Health Fund Membership number

Medicare Ref No Expiry Veterans

☐ Are you making a claim for compensation? Date of injury

☐ Workers' Compensation Claim Number

☐ CTP Insurer

☐ Personal Injury Claim Phone

☐ Public Liability Phone

☐ Sports Insurance

## Declaration

*I have read the Privacy Amendment Act and give permission for correspondence to be sent to my referring doctor, general practitioner, physiotherapist and insurance company where appropriate.*

*I undertake to pay all fees owing to my Surgeon, including in the event that liability is denied or any outstanding accounts that have not been paid in full by my insurer.*

*I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery fees and I will also be responsible for any legal costs incurred.*

Signed by patient or parent/guardian _____ Date _____

Name (Please print)_____

**Please complete the Medical History Form on following page**