Malvern Hill Consulting

New Patient Registration Form

Patient information

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ☐ Other_____ Date of Birth: _____

Full name: _____

Full Address: _____

Mobile:_____ Home: _____ Work: _____

Email:_____ Occupation:_____

Usual General Practitioner (If not referring doctor): _____

GP Address: _____

Next of Kin Name: _____Contact number: _____

Relationship to patient:_____

Medicare Details

Patient Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref No (number before your name): ___

Account Holder if patient is under 18 years of age:

Parent Full Name: _____ Parent Date of Birth:_____

Parent Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Ref No (number before your name): ___

Private Health Insurance Details

Private Health Fund: _____ Membership Number: _____

Do you have hospital cover with your private health fund? ☐ Yes ☐ No

Have you had hospital cover with your health fund for longer than 12 months?

☐ Yes ☐ No: Please specify date or year you joined your health fund: _____

Concession Card/ Work Cover Details

Aged or Disability Pension No: _____ Expiry date:_____

Dept. Veterans Affairs Card No: _____ Expiry date:_____

Dept. Veterans Affairs Card Colour: ☐ White ☐ Gold

Health Care Card No: _____ Expiry date:_____

If your are a Workcover or TAC patient, please provide claim number: _____

Fee Policy/ Privacy Statement

Fee Policy: All consultation fees are due and payable on the day of consultation, Malvern Hill Consulting does not routinely bulk bill patients,
The costs for any surgical procedures will be discussed, if necessary, with you during consultation. DVA, TAC and Workcover are also charged at different rates. Failure to attend a booked appointment, without prior notification, will incur a fee. By signing this form you are agreeing to the practice fee policy.

Privacy Statement: This practice handles personal information in accordance with the Victorian Health Records Act and the Commonwealth Privacy Act. I consent to the handling of my information by this practice for the purpose of providing quality health care, associated administrative and billing purposes. give permission for medical information to be obtained from any other source in order to help with my treatment. I also give permission for medical photography to be used for planning procedures and follow up. Use for teaching, audit research or publication would require additional consent to be obtained. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements,
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

I have read the above fee policy and privacy statement. I consent to the taking and use of my medical records as described. I have viewed the fees and agree to pay the costs of consultations and any surgical procedures performed.

Signature: _____ Name: _____ Date: _____