Patient Registration Form

PATIENT INFORMATION:			
Given Name (include Title):		Surname:	DOB:
Address:			Postal Code:
Home Phone:	Work Phone:	Mobile:	
Email Address			

NEXT OF KIN/EMERGENCY CONTACT:	
Given Name:	Surname:
Contact No:	Relationship to Patient:

DOCTOR'S INFORMATION:		
GP's Name:	Phone:	Fax:
Address:		Postal Code:
Referring Doctor (if different):		
Other Health Professionals:		

INSURANCE DETAILS:		
Medicare Number:		Expiry Date:
Health Insurance Fund:	Membership No:	Gap Cover? ☐ Yes ☐ No
Pension Number:		☐ Disability ☐ Old Age ☐ Others
Veterans' Affairs No:		☐ Gold ☐ White
TAC or WorkCover Insurer Name:		Claim No:
		DOA:
Claims Officer's Name:		Direct Tel:
		Direct Fax:
Employer's Name:		

I authorise Frankston Pain Management to obtain copies of letters, reports and investigation results and to correspond with or discuss my treatment plan with other treating health professionals.

I have read and I accept Dr _____ professional fees and payment arrangements as described in the brief fee schedule dated _____.

I am aware that there may be a gap between the fees charged and my refund and that it is my responsibility to pay the gap amount. I agree to pay all doctors' fees on the day of consultation.

Signed: _____ Date: _____