Windsor Avenue Day Surgery
Mornington Endoscopy
Rosebud Endoscopy

Patient Registration Form

TITLE: □ **MR** □ **MRS** □ **MISS** □ **MS** □ **MSTR**

FIRST NAME: _____ LAST NAME: _____

ADDRESS: _____

PHONE (HOME): _____ (MOBILE) _____ (WORK) _____

DATE OF BIRTH: _____ SEX _____ COUNTRY OF BIRTH _____

EMAIL ADDRESS: _____

MEDICARE NUMBER: _____ No ON CARD: _____ EXPIRY: _____

PRIVATE HEALTH INSURANCE _____ MEMBERSHIP No _____

PENSION/HEALTH CARE CARD No _____ EXPIRY DATE _____

VETERAN'S AFFAIRS NUMBER _____ GOLD CARD □

Are you of Aboriginal or Torres Strait Islander Origin?

No □ Yes, Aboriginal □ Yes, Torres Strait Islander □
Yes to both □ Decline to answer □

GP Details

REFERRING GP _____

ADDRESS/CLINIC _____

Emergency Contact Details

EMERGENCY CONTACT _____ PHONE (HOME): _____

I acknowledge that my personal information may have to be disclosed to, or collected for, Government and Health Fund statistics or to other treating health professionals so that my health care is not compromised. It will, however, be disclosed to other organisations where required by law or if necessary for debt collection purposes.

I, _____, give consent to Windsor Avenue Day Surgery/Mornington Endoscopy/Rosebud Endoscopy to receive and send my health/personal details by fax. I have read and understand the above.

SIGNATURE: _____ DATE: _____