***New Patient Registration Information***

Mr/Mrs/Ms/Miss/Dr **Surname**:…….....…….....……

**Given Name**:……..……..**Preferred Name**:……
As per Medicare card

**Address:** .....…….....……...

**Suburb:**.....…… **Postcode:** ……

**Email Address**:..……..
if applicable

**Date of Birth:** ……..... / ..... / ..... **Occupation**:.....…….....

**Home**: .....…..…… **Work:** .....……**Mobile**: ..…….....

**Referring Doctors Name** .....…….. **GP**: .....……..**GP Suburb**: ..……

**Medicare Number:** ___ ___ ___ ___ ___ ___ ___ ___ ___ (___)

*What is the Reference number to the left of your name on the Medicare card?* (……)

**Pension/HCC/Disability/Carer Pension Card Number:** ……
***Please Circle which Card*** **Note: We do not accept Commonwealth Seniors Card**

**Private Health Fund**:…….....…….. **Fund Membership Number** :.....…….……..

**DVA Gold Card No.**…….. **DVA White Card No**……

***Next of Kin:***

Name: ……..…….....…… Relationship: ……..……..

Home: .....……. Work/Mobile: …….……

**Worker's Compensation or Motor Vehicle Claim Only please complete the following:**

Date of accident: …….. Insurance Company/ICWA: ..... Claim No:.....

WC Only: Employer Name, Address, Manager & Contact Number:

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**Privacy Policy – Patient Consent**

I hereby give my consent for Dr Peter Silbert to collect and use my personal information in order to advise me about my health care, and provide the information to my referring doctor and any other health professional involved in my care, and for account keeping and billing purposes.

Signed: ……. Date: ……