GIS Confidential Patient Registration Form

Surname: ______________________________ **Title:**__________

Given Name: ______________________________ **Date of Birth:** ______ /______ /______

Home Address: ____

Suburb: ______________________________**Postcode:** __________ **State:** ____________

Home Phone: ___________________________**Work Phone:** ______________________________

Mobile Phone: ______________________________

Medicare Number: ____________________________________ **Ref:** ________ **Expiry:** ______ /______

Aged Pensioner? Yes / No **Number:** ____________________________**Expiry:** ______ /______

Private Health Fund? Yes / No

Name Of Fund: ____

Membership Number: ____

Next of Kin Name: ____

Next of Kin Phone: __________________________**Relationship:** ______________________________

GP/Local Doctor: _________________________________ **Phone:** ______________________________

Referring Doctor: (if different from GP) ____

Terms:

1. I have read the GIS Practice information (January 2015)
2. I accept full liability for any WorkCover or TAC claims that are rejected
3. I understand accounts referred to a Collection Agency or Solicitor will have all legal costs and commission added to the amount due.

Signature: ____**Date:**______ /______ /20______