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**Patient Registration Form**

Date: …... /….. /………..

Title: ……... First Name: ……………… Surname: ……………………………………………………………………….

Address: ………………………………………………………………………………………………………………………....

Date of Birth: ...... / …… / ……... Contact Numbers: H: ……………………... M: …………………………………

Email Address: ………………………………………………………………………………………………………………….

Occupation: ………………………………. Name of employer: ………………………………………………………...

□ Consent to receiving text messages from the practice to the mobile number given above.

Were you born in Australia? □ Yes □ No

If not, where were you born: ………………………………. Cultural Background: …………………………………

ATSI (Please Tick) □ Aboriginal □ Torres Strait Islander □ Aboriginal and Torres Strait Islander

**Do you have any previous illness or medical condition we need to be aware of (tick below)?**

□ High blood pressure □ Angina □ Diabetes □ Bleeding tendency □ Stomach Ulcer

□ Asthma □ Hepatitis □ Skin cancer surgery □ Varicose Veins □ Deep vein thrombosis

□ Currently pregnant □ HIV □ Heart valve surgery □Other

**Do you have any allergies or are you sensitive to drugs or dressings:** □ Yes □ No

**Smoking:** □ Yes □ No (How many per day ……….) **Alcohol:** □ Yes □ No (How many per day ……...)

Next of kin/ In case of Emergency: ………………………………………………………………………………………

Relationship: ………………………………… Contact number: ………………………………………………………

Emergency contact if different to the Next Of Kin: …………………………………………………………………

Relationship: ………………………………… Contact number: ……………………………………………………….

Medicare Number: …………………………………………………...… Ref. No…………. Valid To: …………………

Pension Card Number: …………………………………………………… Valid to: …………………………………….

Health Care Card Number: ……………………………………………… Valid to: …………………………………….

DVA Card Number: ………………………………………………………… Valid to: …………………………………….

Private Health Insurance Company Name: ……………………………………………………………………………

Private Health Insurance Policy Number: ………………………………Valid to: ………………………………….

Mission Healthcare is a mixed billing practice. By signing this I agree to the following terms and conditions:

* I understand that some of my consultations may have associated costs.
* I understand that some of these costs may be out-of-pocket fees and others may be eligible for a Medicare rebate.
* I understand that any consultation fees must be paid for on the day of service.
* I have been informed by Mission Healthcare administration staff that Theatre and Procedural fees must be paid on the date of service, and these fees are not eligible for Medicare bulk-billing or rebates.
* I understand that should I need a procedure I must also pay a separate fee for the consultation and that this fee is eligible for bulk-billing or Medicare rebates.
* I understand that medical consultations for new worker’s compensation claims must be paid for on the day of service by myself (the patient), until such a date when the workers compensation claim is approved, and I have been issued a claim number and insurance provider.

Name: ……………………...………………… Signature: ………………………………… Date: …………………………