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# New Patient Registration Form

## 1. Patient Details

- Dr/Mr/Mrs/Ms/Miss .....
- First Name .....
- Middle Name .....
- Surname .....
- Date of Birth .....
- Occupation .....

## 2. Contact Details

- Residential Address .....
- Suburb .....Postcode .....
- State ..... SMS Reminder: YES / NO
- Mobile Number ..... Home Number .....
- Work Number .....
- Email Address .....

## 3. Health Insurance

- Medicare Number ..... Ref..... Expiry ...../.....
- Private Health Fund ..... Membership Number.....

## 4. Referring GP details

- Referring Doctor .....
- Address .....
- Contact telephone number .....

## 5. Next of Kin

- Name of Next of Kin .....
- Relationship to patient .....
- Next of Kin telephone number .....

## 6. Payment

- Payment is required at time of consultation. We accept cash/cheque/major credit/debit cards (ex. Diners and AMEX). We do not Bulk Bill. Please discuss fees prior to seeing the Doctor.

**Consent to Release of Medical Information:**
I hereby give consent to Genesis Women's Health and associates to obtain health and other information from medical practitioners and other organisations I have seen in the past which may be pertinent to my care.

I authorise those medical practitioners and other organisation to release such information to Genesis Women's Health and associates as may be required. I understand that the information sought may contain sensitive health information.

**Patient Signature** ..... **Date** .....