Dr Linda Allen Registration Form

Please complete and return to reception. ***PLEASE PRINT CLEARLY***

Title: (Mr/Mrs/Miss/Ms) Surname…………………………………………………………………………………………………

Given Names: ……………………………………………………………………………….…. Date of Birth..……/………../………

Residential Address: ……

Suburb: ……………………………………………………………………………………………... Postcode: ……..……………..

Telephone: (Home)……..………………….…………………..……. (Business)………. ………………………………………….

Mobile Number: …………………………………………………… Email: ……………..………………………………………………..

We regularly send SMS reminders for pending appointments for your convenience. We sometimes also send results or medication notifications. Please check the box if you **DO NOT** want these to be sent to you. ☐

Occupation: ………………………………………………………… Place of Employ: ..……………………………………………………

Marital Status (please circle): MARRIED SINGLE DIVORCED DE-FACTO

Have you seen Dr Allen previously as a patient? Yes / No

If yes, where: ………..…………………………………..………………………. Date (Month/Year): …………………………….

Next of Kin or Emergency Contact

Title: (Mr/Mrs/Miss/Ms) Full Name:…………………………………………………………………………………………………….

Relationship to Patient: …………………………………………….……… Phone: …..…………………………………………..

Permission to contact if we cannot contact you to confirm your appointment: YES / NO

Referral Details

Referring Doctor: ……………………………………………………………………………..…………………………………

Practice Name: ………..

Address: ….………..

Tel: ……..……………………………….…………………….. Fax: ……………..………………………………..……………………

Family Dr/GP: (if different from referring doctor) ………………………………………………………………………………….

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

Medicare , DVA & Private Health Insurance

Medicare Number: ………………………………………………………….………………..………………… Ref number: …………

Medicare card expiry date ………………………….…… Do you currently have private health insurance? Yes / No

Name of Fund: ……………………………..…………………….…. Membership Number: ……………………………………………

DVA Card Number: …………………….……………..… GOLD / WHITE Disability:……………..…..………………………………..

PLEASE TURN OVER

List any other Doctors who need to be informed of your consultations:

Name: ………………………………………………………………….. Suburb: ………………………………………………………………………

Name: …..………………………………………………………………. Suburb: …………………………………………………………………..

The main purpose for collecting your information is to provide the best possible health care. We must also comply with laws that require collection or disclosure of personal information about you. Please sign below to indicate you consent to your information being released if/when relevant to other medical practitioners who may be involved in your current treatment plan, or clinical audits.

Confidentiality is closely guarded and permission will always be sought in individual event. Information will not be used for any other purpose.

I am responsible for my account and understand that it is to be settled in full on the day of consultation and no accounts will be given.

I am aware of the cancellation policy which states that confirmed appointments, cancelled within 24 hours, will incur a $120 cancellation fee. This amount is payable before another appointment can be made. Appointments which are not confirmed by SMS or phone may be cancelled without notice.

Should I arrive very late for my appointment, I understand that it may need to be rescheduled.

Signature: ……………………………………………………..……………….. Date: ……… / ……… / ………