Dr Christine Thevathasan

Patient Registration

Surname: _____

Given Name (s): _____

Preferred Name: _____DOB: _____

Address: _____

_____

Phone: (H) _____ (W) _____ (M) _____

Email Address: _____

Medicare No: _____ Your Ref: _____ Expiry Date: _____

Do you have private health Insurance? YES ☐ NO ☐

If Yes, which fund? _____ Membership No: _____

Do you wish to be reminded of appointments via SMS? YES ☐ NO ☐

Referring Doctor: _____

Name & address of General Practitioner (if not your referring Doctor):

_____

_____

Next of Kin: _____ Relationship: _____

Phone: (H) _____ (W) _____ (M) _____

Emergency Contact (other than next of kin):

Name: _____ Phone: _____

How did you hear about us? GP ☐ Friend ☐ Our Website ☐ Cabrini Website ☐ Cabrini Hospital ☐

Other: _____

Privacy Statement:

This medical practice collects information from you for the primary purpose of providing quality healthcare. We ask you to provide us with your personal details and full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare needs. We may use the information you provide for administrative purposes in running our medical practice including billing and compliance with Medicare and Health Insurance Commission requirements. Information may be sent/received to other practitioners involved in your care. Confidentiality will always be maintained if any information related to your care is used ini research, quality assurance or educational purposes.

Payment Procedures:

Please advise the receptionist if you are unable to pay your account after your consultation. Patients who do not pay their account after consultation are advised that payment is due within 28 days. **Accounts not paid within 28 days will incur a late fee. We use Debt Recovery service for collection of overdue accounts and any additional charge to us for this service will be passed on to the patient.**

I consent to the handling of my information by this practice for the purpose set out above.
I understand my obligation with regard to payment of my account.

Patient/Guardian Signature: _____Date: _____