New Patient Information

Epworth Sports+Exercise Medicine Group

Personal/Contact Details

Title: First Name: Surname:

Preferred Name:

Date of Birth: Occupation:

Home Address:

Suburb: Post Code: State:

Telephone Private: Business: Mobile:

Email Address:

Medicare: Ref No.(next to your name) Expiry:

Veteran's Affairs (If applicable): Expiry:

Health Care Card/Pension Details: Expiry:

Name of Family Doctor/GP:

Address of Family Doctor:

Do you have a Referral? ☐ Yes ☐ No

☐ Doctor ☐ Physio ☐ Masseur ☐ Podiatrist Other (please state)

Name of Referrer:

Private Health Insurance

Name of Fund: Membership Number:

Next of Kin:

Name:

Relationship: Contact Number:

Payment Details:

N.B. This is not a Bulk Billing practice. Payment in full is required at the time of consultation. Cash, Cheque, EFTPOST, Visa, MasterCard and Bankcard are accepted. Work Cover and TAC patients will be charged private fees and will need to claim the cost of consultations back from their Employer, Work Cover Insurer or TAC. In some situations this may result in a gap between our fees and the amount refunded by the Employer/Work Cover Insurer/TAC. By signing this form you accept the terms and conditions above.

Signed: Date: