# PATIENT REGISTRATION FORM

| | | | |
|---|---|---|---|
| **Title (circle)** | **Ms / Mr / Mx** | | |
| **First Name:** | | **Family Name:** | |
| **Date of Birth:** | | | |
| **Gender:** | | **Pronouns:** | **(Please kindly Indicate)** |
| **Home Address:** | | | |
| **Suburb:** | | **Postcode:** | |
| **Current School:** | | | **Year Level:** |
| **Family Details** | **<u>These are compulsory information.</u>** | | |
| **Medicare Number:** | | **Expiry** | **Medicare Ref No:** |
| **Mother's Full Name:** | | **DoB:** | **Medicare Ref No:** |
| **Father's Full Name:** | | **DoB:** | **Medicare Ref No:** |
| **Sibling 1:** | | **DoB:** | **Medicare Ref No:** |
| **Sibling 2:** | | **DoB:** | **Medicare Ref No:** |
| **Sibling 3:** | | **DoB:** | **Medicare Ref No:** |
| **Parent's Tel:** | **P-1:** | **P-2:** | |
| **Parent's Emails:** | **P- 1** | **P-2** | |
| **Parent's Occupation:** | **P-1:** | **P-2:** | |
| **Parent's Place of Work:** | **P-1:** | **P-2:** | |

| | |
|---|---|
| **Legal Matters** | **Please indicate if parents are either separated or divorced. YES or NO** |
| | **Have there been any Family Court Matters / Proceedings / Intervention Orders and Such?**<br>**If Yes, Please Provide Further Details Below:** |
| **Details:** | |
| | **Referring Doctor's Information** |
| **Doctor(s):** | |
| **Clinic Name** | |
| **Clinic Address** | |
| **Clinic Contacts** | Tel: Fax: Email: |
| | **Payment Information Is Required as there is no admin at this practice.** |
| **Name on Credit Card** | |
| **Credit Card Numbers** | - - - |
| **Expiry and 3 Digit CSV** | **CIRCLE: MASTERCARD OR VISA** |

**Please read and AGREE to the followings;**

- I have provided true and accurate information and I consent for my health records (except bank details) to be viewed by other health care professionals in the event of an emergency.
- I understand, acknowledge and agree that BOTH parents (or Legal Guardians) will have to provide consent prior to consultations.
- **New Patient (New Referral)**; I understand I do need to provide **No Less than 1 week cancellation notice** (before the date of my first consultation). I understand I will be charged Full Consultation Fees for the appts for failing to do so.
- **Follow Up Appt Cancellation**; I understand I do need to provide **No Less than 72 (Business Hours) cancellation notice** (excludes Saturday and Sunday). I understand I will be charged the Full Consultation Fees for; Cancellation less than 72 business hours or Any missed appts (In Person or Telehealth Consultation) and that cancellation charges will be private, personal out of pocket fees as Medicare does not provide any rebates or reimbursements for "Missed / Cancelled / Did Not Attend" appointments.
- I provide "informed financial consent" to be charged for my appts. I understand card charges (as levied by the banks) will apply for all transactions.
- **I understand that when I confirm any appointments, it is deemed that I have read and understood the Practice Information PDF and I have accepted and agreed to all the Terms and Conditions stipulated.**
- I understand that completion of this Registration Form does not automatically guarantee an appt with Dr Lee.

**I hereby, Agree to all the above and also Provide Full Consent for my Child, for Assessment and Therapy with Dr Nazrin Lee:**

**…….Date……**
**(Father to Sign and Print Name Above)**

**…….Date……**
**(Mother to Sign and Print Name Above)**