Patient Registration Form

Title *Mr / Mrs / Miss / Ms / Master/______*

Surname ____ First Name_______________________________________

Date of Birth _________________________________ Preferred Name _____________________________________

Are you of Aboriginal Decent or Torres Strait Islander decent?

☐ *No* ☐ *Yes - Aboriginal* ☐ *Yes – Torres Strait Islander* ☐ *Both*

What is your preferred language? ____________________Country of birth _______________________________

Address: ____

Suburb ____ Postcode _____________________________

Telephone Home _______________________________________ Work _____________________________________

Mobile ______________________________________ Email ____

Medicare Card Number __________________________________ IRN ___________ Expiry____________________

Pension Card Number ____ Expiry ___________________

Healthcare Card Number ____ Expiry ___________________

Dept of Veteran Affairs Card Number ______________________________________ Expiry ___________________

Private Health Fund ____Member No: _____________________

Occupation____ Marital Status _____________________________

Next of Kin Name: ___________________________Phone __________________Relationship ________________

Emergency Contact ___________________________ Phone __________________ Relationship _______________

Referring Doctor name: ____

Referring Doctor's Practice Name and Address: ____

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☐ **Please mark box if you agree to Apex Cardiology SMS for Reminder and Follow up Appointments**

I hereby give express permission to Apex Cardiology staff and Doctors to receive and supply Personal
Medical information from or to other Medical Practitioners/Specialists/Pathology/Radiology etc. on my behalf.
I acknowledge that I am wholly responsible to arrange any further appointments
to discuss test results conducted by my Doctor at all times.
I give permission to be notified by letter, phone, email or text message for all Routine Recalls and Reminders.

HIC Online, For Eligible Bulk Bill Patients
I hereby authorize Apex Cardiology to process my claim through Medicare Australia

Signed ____ **Dated** ______________________________

Please tick if ☐ Parent ☐ Guardian

Admin Internal use. ☐ Medicare Checked Referral Date __________________________________ Initials: __________