Epworth Sports+Exercise Medicine Group

NEW PATIENT INFORMATION

Personal/Contact Details

Title: ________ First Name: ______________________ Surname: _________________________

Pronouns: _______

Preferred Name: ________________________________

Date of Birth: _______________________Occupation: __________________________________

Aboriginal or Torres Strait Islander: Yes / No

Home Address: ____

____Post Code: _______________

Phone: ________________Business____________________

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: ____

Referred by Sports club? Metropolitan ☐ Country ☐ Name of Club ____________________

Private Health Insurance:

Name of Fund: ________________________________ Membership Number: ___________________

Next of Kin
Name: ____________________ Relationship: _______________ Contact Number: _______________

Account Payer
Name: ___________________________ DOB: __________ Medicare Number_________________

Payment Details:

N.B. This is not a Bulk Billing practice.

Payment in full is required at the time of consultation
NB: There will be a surcharge on card payments:
Cash, Cheque, EFTPOS, Visa, Mastercard and Bankcard are accepted.

VISA/MASTERCARD DEBIT (incl. Paypass or tap)	**0.5%**
VISA/MASTERCARD CREDIT	**1%**
EFTPOS – insert card	**FREE**

By signing this form, you accept the terms and conditions above.

Signed: ____**Date**: _________________________