NEW PATIENT INFORMATION

Epworth Sports+Exercise Medicine Group

First Name: _____ Surname: _____

Title:_____ 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: ___/___

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: _____

If a patient is under 18 years of age, Medicare requires a parent/guardian to be the account holder

Account Holder name (1 parent/guardian only)

Name: _____ DOB: _____Medicare #:_____ Ref #:____

Do you consent to receiving text communication from this clinic ☐ Yes ☐ No
Do you consent to receiving email communication from this clinic ☐ Yes ☐ No

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**

A non-attendance fee will be charged if you fail to give 48 hours notice of cancellation.
I have read and understand the attached information on The Private Policy. I have read and agree to the above fees.

Signed: _____**Date**: _____

Referral from a general practitioner is needed to claim from Medicare for specialist consultations. GP referrals are valid for 12 months. **A new referral should be obtained from your GP after 12 months or for a new problem**.