NEW PATIENT FORM

MAXFAC CLINIC

STRICTLY PRIVATE & CONFIDENTIAL

(PATIENT DETAILS & INFORMATION AS REQUESTED BY DEPARTMENT OF HUMAN SERVICES OF VICTORIA HEALTH SERVICES REGULATIONS 2002 & HEALTH SERVICES ACT 1988)

PATIENT DETAILS					
TITLE:	Mr / Mrs / Ms / Master / Miss / Dr				
SURNAME:		GIVEN NAMES:			
ADDRESS:					
SUBURB:		POSTCODE:			
COUNTRY OF BIRTH:					
TELEPHONE (H):					
TELEPHONE (W):					
TELEPHONE (M):					
DATE OF BIRTH:					
GENDER:	male / female / prefer not to say	OCCUPATION:			
NEXT OF KIN / EMERGENCY CONTACT DETAILS					
TITLE:	Mr / Mrs / Ms / Master / Miss / Dr				
SURNAME:		GIVEN NAMES:			
ADDRESS:					
SUBURB:		POSTCODE:			
TELEPHONE (1ST):		TELEPHONE (2ND):			
RELATIONSHIP TO PATIENT:					
PERSON RESPONSIBLE FOR ACCOUNT DETAILS					
TITLE:	Mr / Mrs / Ms / Master / Miss / Dr				
SURNAME:		GIVEN NAMES:			
ADDRESS:					
SUBURB:		POSTCODE:			
TELEPHONE (1ST):		TELEPHONE (2ND):			
RELATIONSHIP TO PATIENT:					
HEALTH PROFESSIONAL DETAILS					
MEDICAL PRACTITIONER:	Dr				
HEALTH INSURANCE DETAILS					
MEDICARE NUMBER:					
HEALTH FUND (HOSPITAL):		MEMBER NO:		WHEN JOINED:	
HEALTH FUND (DENTAL):		MEMBER NO:		WHEN JOINED:	

I understand that payment of the account is my responsibility and that my health fund (if any) will not cover the amount fully. I undertake to pay any further expenses incurred including solicitor's fees, commission and out of pocket expenses, pathology services, other health related costs as well as defaults on overdue accounts.

SIGNATURE: ..... **DATE:** .....

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