The Yarrawonga Medical Clinic

Pty.Ltd. ACN 006 552 334
ABN 26 006 552 334

& Yarrawonga Skin Cancer Clinic

Patient Registration Form

Print this form out / complete the form and bring it with you on your first consultation.

*** Compulsory Fields (must be filled out)**

*Mr Mrs Ms Miss (circle one)

*First Name:_____ Surname:_____

*Date of Birth: ___/____/_____ * Sex: Male❒ Female❒ Preferred Name: _____

*Are you of (please tick if applicable) - Aboriginal ❒ Torres Strait Islander ❒

*Country of Birth/Ethnicity: _____ Religion: _____

*Address:_____ Postcode: _____

*Contact Ph No:_____ Work Ph No:_____

*Medicare Card No._____ Ref No. _____ Expiry Date: _____

*If Pensioner or HCC, No._____ Expiry Date: _____

*If DVA Patient, DVA No. _____ Expiry Date: _____

*Emergency Contact Name:_____*Contact Phone No. _____

*Next of Kin Name: _____

*Next of Kin Relation: _____*Next of Kin Contact No.: _____

☐ I wish to register for My Health Record. (please tick box to confirm)

(Signature of patient)..... (Date)...../...../.....

Please note: Payment is required on day of consultation.

Our terms provide that in the event of this account remaining unpaid and being referred to a debt collection agency and/or law firm, all collection and legal demand costs will be added to the account.

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