cura
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Patient Registration Form - Paediatric

Patient Details

Title _____ Given Names _____ Surname _____

Date of Birth _____ Gender _____ Email _____

Home _____ Mobile _____ Language Spoken at Home _____

Address _____

Suburb _____ State _____ Postcode _____

Medicare/ Private Health Details

Medicare Number |__|__|__|__| |__|__|__|__|__| |__| Number preceding your name |__| Expiry |__||__| / |__|__|

Health Insurance Fund _____ Member No. _____

Type of Cover _____ Excess Amount _____

Parent/ Legal Guardian Details 1

Title _____ Given Names _____Surname _____

Relationship to Patient _____ Date of Birth _____

Medicare Number |__|__|__|__| |__|__|__|__|__| |__| Number preceding your name |__| Expiry |__||__| / |__|__|

Parent/ Legal Guardian Details 2

Title _____ Given Names _____Surname _____

Relationship to Patient _____ Date of Birth _____

Medicare Number |__|__|__|__| |__|__|__|__|__| |__| Number preceding your name |__| Expiry |__||__| / |__|__|

Who is the person responsible for the account? ☐ Parent/ Legal Guardian 1 ☐ Parent/ Legal Guardian 2

Are there any custody or guardianship orders that the staff should be aware of? ☐ Yes ☐ No

(If yes, please provide current documentation)

Current GP

Name _____

Phone Number _____ Fax Number _____

Address _____

Suburb _____ State _____ Postcode _____

Current Optometrist

Name _____

Phone Number _____ Fax Number _____

Address _____

Suburb _____ State _____ Postcode _____

I certify that the information given above is correct to the best of my knowledge. I understand that I am liable for all charges associated with the consultation and that a cancellation fee of $80 will be charged if I cancel my appointment with less than 24 hours notice.

Signature of patient/ parent / guardian _____ Date _____

Please print name: _____