REGISTRATION

Albert Road Clinic
Part of Ramsay Health Care

Dr Mahendra Perera
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PLEASE COMPLETE BOTH PAGES 1 & 2

Personal Details

TITLE: Mr. ☐ Mrs. ☐ Ms. ☐ Mx. ☐ Other ☐ (please list):

How you would like to be addressed (nickname or preferred name):

SURNAME:

FIRST NAME: MIDDLE NAME:

STREET ADDRESS:

SUBURB: POSTCODE:

DATE OF BIRTH (DD/MM/YYYY): / / GENDER: Male ☐ Female ☐ Other ☐

MOBILE: ( ) EMAIL:

MEDICARE NUMBER: MEDICARE CARD REFERENCE #:
(the single digit against your name)

MEDICARE CARD EXPIRY DATE (MM/YYYY): /

NAME OF NEXT OF KIN: RELATIONSHIP:

STREET ADDRESS:

SUBURB: POSTCODE:

TEL. NEXT OF KIN: ( ) EMAIL:

DO YOU HAVE PRIVATE HEALTH INSURANCE (Please tick): YES ☐ NO ☐

IF YES, WHICH FUND:

MEMBERSHIP NUMBER: TABLE / LEVEL:

(Please continue to Page 2)

Your Regular General Practitioner (GP):

PRACTITIONER NAME:

STREET ADDRESS:

SUBURB: POSTCODE:

TELEPHONE: ( ) FAX: ( )

EMAIL:

Pharmacist Information:
(If you will require medicines, please provide information for your Pharmacist below.)

NAME OF PHARMACY:

STREET ADDRESS:

SUBURB: POSTCODE:

TELEPHONE: ( ) FAX: ( )

EMAIL:

Please Read the Following

- I hereby grant permission for my next of kin to be contacted and given any relevant information in an emergency or if the situation warrants.
- I understand that a Cancellation fee may be charged to me for appointments missed or cancelled without informing us at least one business day prior to the appointment.
- I understand that my personal information may be used by other health care professionals for my medical care especially if Dr Perera is unavailable.
- SMS reminders are usually sent the day before the appointment.
- I have read the accompanying materials.
- We will contact you by SMS, Email or Post **(unless otherwise instructed)**
- I agree to the above terms and conditions.

SIGNED:

TODAY'S DATE (DD/MM/YYYY): / /

☐ By checking this box, you agree that the name or mark above constitutes your electronic signature and agreement to the terms outlined herein.