Registration

Dr Mahendra Perera
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Consultant Psychiatrist
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Please complete all three pages, *add your signature at the end of page 3*, and return to Dr Perera with the other forms prior to your appointment. Your signature is required. If you are unable to sign the form and return via email, please print the form and return with the other forms via fax or post.

Photograph

Please attach a recent 'passport type' photograph for our records.

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: / / Gender: Male ☐ Female ☐ Other ☐

Mobile: ( ) Email:

Next of Kin Name: Relationship:

Next of Kin Address:

Suburb: Postcode:

Next of Kin Tel: ( ) Email:

Medicare and Insurance

Medicare Number: Medicare Card Reference #:
(the single digit against your name)

Medicare Card Expiry Date (MM/YYYY): /

Do you have Private Health Insurance? (Please tick): YES ☐ NO ☐

If yes, which fund:

Membership Number: Table/Level:

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General Practitioner (GP)

Practitioner Name:

Street Address:

Suburb: Postcode:

Telephone: ( ) Fax: ( )

Referring Practitioner

If you were referred by a practitioner other than your General Practitioner (GP), please provide their information below.

Practitioner Name:

Street Address:

Suburb: Postcode:

Telephone: ( ) Fax: ( )

Pharmacist

For those who may require medications, please provide Pharmacist information below. This is mandatory if you are seeking ADHD medication.

Pharmacist Name:

Street Address:

Suburb: Postcode:

Telephone: ( ) Fax: ( )

Email:

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Third Party Payment

If part of your financial obligations for treatment will be fulfilled by Transport Accident Commission (TAC), Work Cover or other third party (including parents and other relations) please provide their contact information below, so that we will be able to confirm the arrangement and invoice as appropriate. **We will require proof of acceptance to make payment, e.g. – a letter or statement of benefits.**

Third Party Name:

Case Manager Name (if applicable):

Case Number (if applicable):

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 hereby grant permission for billing and appointment information to be provided to the third party indicated above for the purpose of fulfilling all or part of my financial obligations for treatment.
- 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 sent 48 hours before the appointment. Please confirm or let us know otherwise.
- I have read the accompanying materials.
- We will contact you by SMS, Email or Post **(unless otherwise instructed)**
- Copies of letters to your GP will be emailed **(unless otherwise instructed)**
- I agree to the above terms and conditions.

SIGNED:

TODAY'S DATE: / /

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