A/Prof Wan Tinn TEH

MBBS FRANZCOG MRMed PhD
Gynaecologist & Fertility Specialist

NEW PATIENT REGISTRATION FORM

This information is used for admin and healthcare staff to correctly identify, invoice and assist you. It is entirely confidential.

Title	☐ Miss ☐ Ms ☐ Mrs ☐ Mr ☐ Mx ☐ Dr ☐ Other (specify) _____		
Given Name/s *Name/s on Medicare/OSHC*		**Last Name**	
Known as *Preferred Name*		**Date of Birth** *DD/MM/YYYY*	
What was your SEX recorded at birth? *This information is collected to inform the care you receive*		☐ Female ☐ Prefer not to say ☐ Male ☐ Another term (Specify) _____	
How would you describe your GENDER? *This may differ to sex recorded at birth and/or what is indicated on legal documents*		☐ Female ☐ Prefer not to say ☐ Male ☐ Another term (Specify) _____	
Pronouns *Tick all that apply*	☐ She/her ☐ He/Him ☐ They/them ☐ Prefer not to say ☐ Other (specify) ____		

Street Address			
Suburb		**Postcode**	
Mobile Number			
Email Address			

Medicare Details	**Private Health Insurance Details**
Medicare Number _____ Ref # _____ Expiry date _____/_____	Insurance Name: _____ Membership No. _____Ref # _____

Occupation			**Preferred Language**	☐ English ☐ Mandarin
Next of Kin	**First name**		**Last name**	
	Mobile		**Relationship**	

Referring Doctors Details

Clinic Name	
Doctor Name	
Clinic Phone No.	

Regular GP Details *If different from referring doctor*

Clinic Name	
GP Name	
Clinic Phone No.	

Send correspondence to both doctors? ☐ Both ☐ Referring Doctor Only ☐ Regular GP Only

Partner's Registration Details (If applicable)

Title	☐ Miss ☐ Ms ☐ Mrs ☐ Mr ☐ Mx ☐ Dr ☐ Other (specify) _____		
Given Name/s *Name/s on Medicare/OSHC*		**Last Name**	
Known as *Preferred Name*		**Date of Birth** *DD/MM/YYYY*	
Address	Same as above ☐		
Mobile Number		**Email**	
Medicare Details	**Number** _____ **Ref #** _____ **Expiry date** _____/_____		

Fees

Please note that this is a private billing clinic and full payment is required on the day of consultation. If you have any queries about fees, please contact reception prior to your appointment. Additional fees may arise during treatment.

Privacy statement

I _____ (print name) understand that this medical practice collects my information for the primary purpose of providing quality healthcare. Information I provide may be used for administrative purposes including billing and compliance with Medicare and Health Insurance Commission Insurance requirements. Information may also be sent to other practitioners involved in my care while at other times, information regarding my care may need to be obtained from other healthcare providers. Confidentiality will always be maintained if any information related to my care is used in research, quality assurance or educational purposes.

Signature: _____ Date: ____ / ____ / _____