

**Patient Registration Form**

It is important that you complete ALL sections of this registration form. You do not need to fill this in if you have already registered your details on-line via your [Patient Portal](#). A registration link would have been sent to your email address at booking.

<b>Title:</b>		<b>Given Names:</b>		<b>Surname:</b>	
<b>Preferred Name:</b>		<b>Maiden Name:</b>		<b>Date of Birth:</b>	/ /
<b>Address:</b>				<b>Postcode:</b>	
<b>Home:</b>		<b>Mobile:</b>		<b>Work:</b>	
<b>Email:</b>					
<b>Medicare No:</b>		<b>Reference No:</b>		<b>Expiry Date:</b>	/ /
<b>Health Fund:</b>		<b>Membership No:</b>			
<b>Next of Kin:</b>		<b>Relationship:</b>		<b>Mobile:</b>	

**Partner Information**

<b>Title:</b>		<b>Given Names:</b>		<b>Surname:</b>	
<b>Preferred Name:</b>		<b>Relationship:</b>		<b>Date of Birth:</b>	/ /
<b>Address:</b>				<b>Postcode:</b>	
<b>Home:</b>		<b>Mobile:</b>		<b>Work:</b>	

**FINANCIAL CONSENT:**

Please note that this is a private billing clinic and the consultation fee would have been advised to you when you made your appointment. Payment is required on the day of the consultation. If you have any queries about the fee please discuss with reception prior to your appointment.

Please note any credit card information you enter into this Patient Portal will be stored securely by [STRIPE](#) online payment system for your convenience. We will use STRIPE to process your invoice after your appointment.

**CLINIC CORRESPONDENCE:** From time to time, we may communicate with you via the email address you have provided. These may including letters regarding your medical information or results. Please let us know in writing if you do not wish for us to do so.

**PRIVACY STATEMENT:** This medical practice collects information from you for the primary purpose of providing quality healthcare. We ask you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare needs. We may use the information you provide for administrative purposes in running our medical practice, including billing and compliance with Medicare and Health Insurance Commission requirements. Information may be sent to other practitioners involved in your care. Confidentiality will always be maintained if any information related to your care is used in research, quality assurance or educational purposes. By attending this clinic, you have agreed to the above. A copy of our privacy policy is available on request.

**IN CLINIC ULTRASOUND SCANS IN FERTILITY TREATMENTS** During fertility treatments, ultrasound scans will be performed to monitor progress. Please be advised these scans will be internal vaginal ultrasound scans.

**By attending this clinic, you have agreed to the above.**

I consent to the above.

**Signed:** \_\_\_\_\_ **Date:** / /

**Please note: Any costs related to IVF or IUI treatment is separate from this practice. Where tests are ordered from external entities (such as pathology and radiology) costs will be incurred which may or may not be covered by Medicare or private health insurance. You should make your own enquiries as to costs with these entities prior to undergoing the test (or procedure where material may be sent for testing) particularly where you are not covered by Medicare.**