BODY GENESIS
INSTITUTE
WEIGHT LOSS AND GUT HEALTH SOLUTIONS
Phone: 03 9466 7799 Fax: 03 8080 9849

PATIENT REGISTRATION FORM

TITLE: _____ FAMILY NAME: _____

GIVEN NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: Home: _____ Work: _____

Mobile: _____ Email: _____

Please Tick to Select: ☐ YES - to be contacted via email in the future

OCCUPATION: _____

NEXT OF KIN: _____ PHONE NO: _____

MEDICARE NO: __ __ __ __ __ __ __ __ __ __ __ REF NO: _____ EXPIRY DATE: ____/ _____

PENSION NO: _____ HEALTHCARE CARD: _____

VETERANS' AFFAIRS (If applicable) _____

PRIVATE HEALTH FUND: _____

MEMBERSHIP NO: _____

REFERRING DOCTOR: _____

LOCAL DOCTOR: (If different to referring doctor and you wish correspondence sent to this doctor)

_____ ADDRESS: _____

WORKCOVER/TAC CLAIM NO: _____

Date of Accident: _____ Employer : _____

Employer's Address:_____

Contact Person: _____ Phone: _____

Insurance Company: _____ Phone: _____

Privacy Statement:

As part of your medical care, your personal and health related information will be collected. Occasionally information will need to be shared between medical practitioners, hospitals and allied health staff in order to manage your health. De-identified information is also collected for auditing, quality assurance and research purposes. If you do not wish your information to be passed on to other medical practitioners or allied health staff, please bring this up during the consultation. I consent to the collection and disclosure of my information as outlined above.

Signed: _____Date:_____

How did you hear about us: GP ☐ Internet ☐ Friend ☐ Patient ☐ Other

Please email this form to admin@bodygenesis.com.au