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PATIENT REGISTRATION FORM

1. Today's date:

2. **Last Name:** Marital status (circle one)

First: Middle:

Mr.

Mrs.

Miss

Ms. Single / Mar / Div / Sep / Widow

Is this your legal name? If not, what is your legal name? (Former name): Birth date: Age:

3. **Sex:**

Yes No // M F

4. **Address:**

5. **Contact details:**

Phone:

Mobile:

Email:

6. **Occupation:** Employer:

7. **Referred to service by** (please check one box): Self Dr. [surname]: Other:

8. **List of Medications & Dosage:**

Current Medical Conditions:

9. **Special Notes:**

- **Do you hold a current pension/concession/student card?** No Yes Type: No.
- **Is your own personal income less than \$27,000 per year?** Yes No
- **Have you been the victim of violent crime in the last 12 months?** Yes No
- **What do you hope to have achieved following psychological treatment or counselling?**

1.

2.

3.

10. How did you hear about service? Family/friend GP/other professional Website
Yellow Pages Local Paper Other

11. Did you experience any problems making an appointment?

12. Did you find the length of time that you had to wait for an appointment acceptable?

13. How did you find the cost of the service compared to others that you may have contacted?

14. Do you have any other comments, complaints or suggestions?

15. Does your private health insurance cover you for psychological services? Yes No
Don't have health insurance

16. Please indicate name of insurance company | Latrobe Health Services Australian
Unity GMHBA Medibank Private
MBF HBA Other (please specify):

17. Type of Insurance Cover:
Membership/Policy Number:

18. Date of Injury/Accident:
WorkCover TAC

Claim Number:
Type of Injuries Sustained:
Insurance Agency:
Billing Address:

19. Contact Person: Phone Number:

Next of Kin: Relationship to patient: Ph. Mobile:

20. Regular Doctor(s): Clinic Address: Ph: After hrs: