sa heart
first choice in cardiology

PATIENT INFORMATION

Title: Dr ○ Mr ○ Mrs ○ Ms ○ Miss ○	**Surname:**	
First name:	**Middle name:**	
Sex: M ○ F ○	Date of birth:	
Postal address:		
Suburb:	Post Code:	
Home phone no:	Work no:	
Mobile no:		
Email address:		
Medicare no:	No. next to your name :	Valid until:
Veteran Affairs Card no:	Type: Gold / White	
Pension no:	Health Care Card no	
Do you have private health insurance Y ○ N ○		
Do you have hospital cover? Y ○ N ○		
Health Fund :	Membership no:	
Family Doctor's Name:		
Address:		Suburb:
Your occupation:		Company name:
Next of kin full name:		Relationship:
Home no:	Mobile No:	Work No:
Allergies to medications: Y / N If yes, please specify:		
Is this a Workcover / Insurance claim:	Y ○ N ○	

Person Responsible for Account

(NB: Only complete if person responsible for payment *is not the patient*)

Surname:	First name:	DOB:
Postal Address:		
Post Code:	Relationship:	
Home phone no:	Mobile:	Work:
Medicare no:	Ref no:	Valid until:

Account Payment Responsibility

Please be advised that out-of-pocket costs may be incurred and payment is required on the day of service. For services covered by Medicare, payment of the account in full is the most convenient payment arrangement; if payment in full is not possible then gap payment is required on the day of payment and it is the patient's responsibility to forward the Medicare cheque to SA Heart as soon as it is received. For services not covered by Medicare, full payment on the day of service is required. A collection fee will be charged for overdue accounts. Thank you for your assistance.

Patient/guardian signature: _____ Date: _____

Office Use Only Patient #:	Registered by:	Date: