sa heart
first choice in cardiology

PATIENT INFORMATION

Surname:	First name:	
Title: Dr ◯ Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Master ◯		Sex: M ◯ F ◯
Date of birth:		
Postal address:		Suburb:
Post Code:	Email:	
Home #:	Work #:	Mobile #:
		Allow SMS reminders: Y ◯ N ◯
Occupation:		
Company name:		
Next of kin full name:		Relationship:
Home #:	Work #:	Mobile #:

Medicare #:	Ref #:	Expiry:
Pension #:	Health Care Card #:	
Veteran Affairs Card #:	Type: Gold ◯ White ◯	
Private Health Fund:	Fund #:	Fund plan: Hosp ◯ Extras only ◯
Workcover / Insurance claim: Y ◯ N ◯		
If yes, claim details:		

Family Doctor's Name:	
Address:	Suburb:
Allergies to medications: Y ◯ N ◯ (please specify)	

Person Responsible for Account

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

Surname:	First name:	DOB:
Postal Address:		
Post Code:	Relationship:	
Home #:	Work #:	Mobile #:
Medicare #:	Ref #:	Expiry:

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: