PATIENT INFORMATION

SAHeart quality cardiac care

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 phone no:	Mobile no:	Work no:
Allergies to medications: Y / N - If yes, please specify:		
Is this a Workcover / Insurance claim:	Y / N	

SA Heart's Privacy Policy is available at saheart.com.au

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 no:	Work no:
Medicare no:	Ref no:	Valid until:

Account Payment Responsibility

Please be advised that out-of-pocket costs may be incurred. It is SA Heart policy that full payment of your account is required on the day of service. For services covered by Medicare an online claim will be lodged. Eligible rebates will be paid directly into your bank account providing this is registered with Medicare. For services not covered by Medicare, full payment on the day of service is required. A collection fee may be charged for overdue accounts. Thank you for your assistance.

Patient/guardian signature: _____ Date: _____

Office Use Only Patient #:	Registered by:	Date: