DR RUCHI SINGH MBBS, MD, MRCOG, FRANZCOG
UROGYNAECOLOGIST & PELVIC RECONSTRUCTIVE SURGEON

NEW PATIENT REGISTRATION FORM

FIRST NAME: _____ **SURNAME:** _____

DATE OF BIRTH: _____

ADDRESS: _____

PHONE:_____**MOBILE**_____

EMAIL:_____ O**CCUPATION:**_____

LANGUAGE SPOKEN: _____**INTERPRETER REQUIRED:** YES / NO

MEDICARE NUMBER: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

REFERENCE NUMBER (Appears next to your name): _____ **EXPIRY:** ____ / ____

PRIVATE HEALTH FUND NAME: _____ **MEMBER NO:**_____

HAVE YOU HAD YOUR PRIVATE HEALTH INSURANCE FOR LONGER THAN 12 MONTHS: YES / NO

DEPT. VETERANS AFFIAIRS NUMBER: _____

DOES IT COVER MEDICAL EXPENSES: YES / NO

GOV CONCESSION CARD: ____ ____ ____ - ____ ____ ____ - ____ ____ ____ ____ **EXP:** ____/____

NEXT OF KIN: _____ **RELATIONSHIP:** _____ **PHONE:** _____

REGULAR GP (IF DIFFERENT FROM REFERRING DOCTOR): _____

CLINIC NAME & ADDRESS: _____

CURRENT MEDICATIONS:_____

_____

Privacy Statement:
Dr Ruchi Singh collects your information for the primary purpose of providing quality healthcare. She asks that you provide her with your personal details and a full medical history so that she may properly assess, diagnose, treat and be proactive in your healthcare needs. She may use the information you provide for administrative purposes in the running of her medical practice, including billing and compliance with Medicare and Health Insurance Commission requirements. Information may be sent to other practitioners involved in your care. Confidentiality will always be maintained if any information related to your care is used in research, quality assurance or educational purposes.

Payment Agreement:
The policy of this practice is payment on the day of consultation. If payment presents a difficulty, please speak with the secretary before your consultation. If you do not have private health insurance (hospital cover), please be aware that procedures requiring admission to Hospital will generate significant out of pocket costs. Please sign to confirm that you have read and understand our policy before you meet Dr Singh.

SIGNATURE: _____ **DATE:** _____