Victorian Children's Clinic – Patient Registration Form

Victorian Children's Clinic
ABN: 39 364 072 040
149 Wattletree Road
Malvern VIC 3144
T: 03 9509 2244
F: 03 9509 2833
victorianchildrensclinic.com.au

Patient's First name: _____

Patient's Surname: _____

Patient's Pref.Name: _____

Date of Birth: ____/____/____

Gender: M ☐ F ☐

Address: _____

_____

Medicare No: | | | | | | | | | | |

Expiry date: _____ Ref. No: _____

Private Health Fund (for eligible services): _____ Member #: _____

Parent 1:		**Parent 2:**	
First Name:		First Name:	
Surname:		Surname:	
Relationship to patient:		Relationship to patient:	
Address:		Address:	
Occupation:		Occupation:	
Phone (h):		Phone (h):	
Phone (w):		Phone (w):	
Phone (m):		Phone (m):	
Email:		Email:	

Are there any court orders/custody arrangements for the child? Yes ☐ No ☐

If yes, please provide a copy of the court orders with your registration form.

Person responsible for Account: _____

D.O.B: _____ Medicare # _____ Ref. No: _____

Expiry: _____

(Please complete Account Holder details in full – to submit your account to Medicare we require the parent/guardian details.)

Referring Dr Name: _____

Clinic Address: _____

Clinic Phone: _____

Family Dr Name: (If different from above) _____

Clinic Address: _____

Clinic Phone: _____

I have received a copy, read and understood the Victorian Children's Clinic Privacy and Cancellation Policies.

Signed: _____ Date: _____