Victorian Children's Clinic - Patient Registration

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:
(as stated on Medicare card) _____

Patient's Surname:
(as stated on Medicare card) _____

Patient's Pref. Name: _____

Sex: M ☐ F ☐

Gender Identity:

D.O.B: __ / ___ /____ **Pronouns:**

Address: _____

_____

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

Expiry date: _____ Ref. No: _____

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

Are there any court orders/custody arrangements for the child? Yes ☐ No ☐
If yes, you must provide a copy to the clinic.

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

We will email clinical correspondence to you, rather than post, unless you nominate otherwise.

If you do not wish to have correspondence sent by email, please tick this box ☐

Preferred Email: _____ Alternative Email: _____

Person responsible for Account* _____ Date of Birth: / /

Medicare #: _____ Reference #: _____ Expiry Date: /

*Please complete Account Holder details in full. To submit your child's account to Medicare we require their parent/guardian details.

Referring Doctor Details:		**Family Doctor Details:** If different to Referrer	
Name:		Name:	
Clinic Name:		Clinic Name:	
Clinic Address:		Clinic Address:	
Telephone:		Telephone:	

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

Signed: _____ **Date:** _____