south coast VEIN INSTITUTE

South Coast Vein Institute
Warrnambool Suite 13, 136 Botanic Rd, Warrnambool, Victoria 3280
Mt Gambier 20 Sturt St, Mount Gambier, South Australia 5290
Camperdown 7 Robinson St, Camperdown, Victoria 3260
Phone (03) 5562 5330 **Fax** (03) 5562 5360 **Email** info@scvi.net.au
www.scvi.net.au

CONFIDENTIAL PATIENT REGISTRATION-Vein Clinic

Dr / Mr / Mrs / Ms / Miss / Master (Please circle)
Surname: ……
Given names: …… Preferred Name: ……
Address: …… Suburb: ……
Postcode: …… Date of Birth: ……

Telephone Numbers
Home: …… Work: ……
Mobile: …… Email: ……

* An SMS reminder will be sent to your mobile 24 hours prior to your appointment

Next of Kin
Name: ……..Relationship: ……
Contact Phone No: ……

Account Holder - For patients under 18 years of age please list the person responsible for your account.
Name: …… Date of Birth:……
Contact No: ……
Address:……

Doctor Information - Please provide full details of your GP
GP Name: …….. GP Address ……

Medicare Details

Medicare Number: _ _ _ _ _ _ _ _ _ _ _ **Ref No.: _

Valid To: _ _ / _ _ _ _

Insurance Details
Do you have Private Health Insurance for **Hospital Cover**? (Circle) YES NO
Have you been with your Health Insurer for more than 12 months? (Circle) YES NO
Health Fund Name: …….. Membership No:……

Concession Card Holders

Pension No:…… Exp Date: ……
Health Care Card No: …… Exp Date: ……
Disability Pension No: …… Exp Date:……

Please Turn Over To Complete →

Third Party Claims

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Veterans' Affairs No.: ……..…… Card Colour: ……..

TAC Claim No.: ……

Work Cover: (Employer details)……..

Claim No.:……

Medical History

Are you allergic to any medicines, tapes or latex? (Please circle) YES NO

If **YES** please give details:

…….

AUTHORISATION AND CONSENT TO PHOTOGRAPHY

I hereby consent that photographs be taken of me by WPRS. WPRS at all times respects patients rights to privacy and informed consent for procedures within the practice including photographic records. I understand that these photographs form an essential part of my medical record, as well as my pre-treatment and post-treatment assessment. I understand and consent to my photographs being used by WPRS for medical research and education purposes and that in such use I will not be identified by name or portray features that shall make my identity recognisable.

Signature:_____ Date: _____

FINANCIAL CONSENT

All new patients, will incur a $200.00 fee for 30-minute consultations, with a Medicare rebate of $73.85. **All accounts are to be paid in full at time of consultation**. Patients who elect to have procedures in the rooms or privately, may incur costs that may not be fully covered by Medicare/ health funds. These costs will be fully declared by WPRS at time of consultation.

I have been informed of the potential costs involved in attending WPRS and understand that payment of my account is my responsibility. I accept that if I default on my account, my details will be passed on to a debt collection agent, with all fees associated with such collection payable by me.

Signature_____ Date: _____

WPRS MAILING LIST

Please provide your email address if you are interested in receiving our monthly newsletter, exclusive promotional offers and educational materials from time to time.

Email: _____