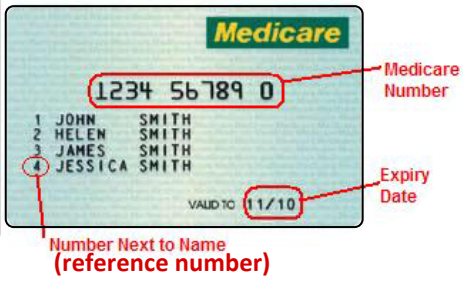
PATIENT INFORMATION FORM

Please complete all sections of this form to ensure confidential records and successful Medicare claiming. A person should be nominated as *Account Holder* and will be listed as such in our records. They will be the claimant for Medicare purposes. The *Account Holder* can be changed if needed.

Paediatrics at Burnside

PATIENT DETAILS				**ACCOUNT HOLDER DETAILS** *(person to receive Medicare rebates)*			
First Name				Name			
Middle Name				Relation to child			
Last Name				DOB		Gender	
Known as				Mobile			
DOB		Gender					
Home Phone				**OTHER PARENT DETAILS** *(or alternate next of kin contact details)*			
Best Email				Name			
Postal Address				Relation to child			
				DOB		Gender	
Suburb				Mobile			
State		Postcode					
Street Address	as above or:						

MEDICARE DETAILS



Child's Medicare Number			
Reference Number		Expiry	_ _ / _ _
OR Child does not yet have Medicare number			Y / N
Is the Account Holder's Medicare number as above?			Y / N
Account Holder's Reference Number		Expiry	_ _ / _ _ *OR* as above
OR Account Holder Medicare No.			
Is the Other Parent's Medicare number as above?			Y / N
Other Parent's Reference Number		Expiry	_ _ / _ _ *OR* as above
OR Other Parent's Medicare No.			

OTHER DETAILS *(if applicable/known)*	
PRIVATE HEALTH INSURANCE	
Fund Name	
Membership No.	
Child's Reference No.	
CENTRELINK HEALTH CARE CARD OR PENSION	
CRN of child	
Expiry	
DVA No. (if child included)	
WOMEN'S & CHILDREN'S HOSPITAL	
Child's Record No.	
NATIONAL DISABILITY INSURANCE SCHEME (NDIS)	
Child's No.	

Language of parents if not English	
Interpreter needed	Y / N

REFERRING DOCTOR *(or best recollection)*	
Referrer Name	
Specialty	
Clinic Name	
Street Address & Suburb	
USUAL GP *(or usual clinic)*	As above/below? Y / N *continue if no:*
Preferred Doctor	
Clinic Details	