MBMC new patient registration form (page 1)

Please fill out the following form to enable us to record your details correctly. Thank you. **Date:**

Patient: Surname:_____ First Name: _____

Date of Birth: __ __ /__ __/__ __ __ __ Gender: Male / Female / Other

Do you identify as being of Aboriginal and/or Torres Strait Islander origin?

Aboriginal Yes Torres Strait Islander Yes Neither: Yes

Country of birth: _____Cultural Identity (Ethnicity) _____

Home Address: _____

Mobile Phone:_____Email:_____

Medicare Number: __ __ __ __ __ __ __ __ __ __ Ref No: __ __ Expiry: __ __ / __ __

HCC/Pension Card Number:_____ Expiry: __ __ / __ __

DVA Card Number:_____ Please Circle: White card / Gold Card

White card approved conditions:_____

Emergency Contact Name: _____ Phone: _____

Allergies: _____

I consent to have my consultation uploaded to My Health Record: Yes No

Do you consent to SMS reminders: Yes No

Do you authorise MBMC to submit benefits on your behalf to Medicare? Yes No

Do you authorise MBMC to contact you via email? Yes No

The practice participates in Quality Improvements in conjunction with the Department of Health. As part of this process de-identified health statistics are shared with the Department of Health. If you wish to opt out please discuss further with the doctor.

I AM AWARE OF THE FEES TO BE CHARGED AND I AGREE TO PAY THEM IN FULL.

Signed _____ Date: _____

ACCOUNT HOLDER / HEAD OF FAMILY (<u>required if patient is 17 or under</u>)

Surname:_____ First Name: _____

Date of Birth: __ __ /__ __/__ __ __ __ Gender: Male / Female / Other

Phone Number: _____ Email: _____

Relationship to child: _____

Medicare Number: __ __ __ __ __ __ __ __ __ __ Patient No: ___ Expiry: __ __ / __ __

Please Turn Over…..

MBMC registration form (page 2)

PATIENT NAME

Please complete to the best of your ability and give this to the Doctor

SOCIAL HISTORY

Smoking Yes No How many per day? _____

Ex-smoker Yes No How many per day? _____

When was your last eye check (year)? _____

Alcohol: How many standard drinks per day? _____

How often do you have a drink containing alcohol? _____days per week.

How often do you have 6 or more alcoholic drinks on any one occasion?

Weekly Monthly Never

ALLERGIES? Yes No

What are you allergic to? _____

What is the reaction? _____

FAMILY HISTORY

_____

_____

Signed _____ Date: _____

SAMPLE CONSULTATION FEES (as at 1.7.2023)

	CASH	HCC	PENS	
Item 23 Level B Consult	**$** 93.45	$ 82.95	$ 77.70	
Gap	***$ 52.25***	***$ 41.75***	***$ 36.50***	
Item 36 Level C Consult	$131.95	$121.45	$116.20	
Gap	***$ 52.25***	***$ 41.75***	***$ 36.50***	
Item 37 Level C Home Visit	$190.50	$171.95	$168.70	
Gap	***$ 81.95***	***$ 63.40***	***$ 60.15***	
Item 585 Afterhours	$241.90	$225.75	$220.65	
Gap	***$ 99.70***	***$ 83.55***	***$ 78.45***	**(emergency consult)**
Item 599 Afterhours visit	$315.25	$280.25	$265.00	
Gap	***$147.70***	***$112.70***	***$ 97.45***	**(between 11pm-7am)**
Item 57524 Xray leg	$164.35	$137.65	$ 34.95	
Gap	***$119.05***	***$ 92.35***	***$ 89.65***	
Item 57512 Xray arm	$156.60	$133.15	$130.40	
Gap	***$119.50***	***$ 96.05***	***$ 93.30***	
Item 58500 Xray Chest	$144.50	$126.50	$122.65	
Gap	***$112.10***	***$ 94.10***	***$ 90.25***	
Item 11707 ECG	*$ 76.00*	*$ 71.10*	*$ 67.85*	
Gap	***$ 58.85***	***$ 53.95***	***$ 0.70***	