MENTAC.
MELBOURNE
EAR, NOSE & THROAT
& AIRWAY CLINIC

CONSULTING LOCATION
52 Templestowe Road, Bulleen VIC 3105

CONTACT
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NEW PATIENT REGISTRATION FORM

Title: (Please circle) Mr Mrs Ms Miss Master Mx Dr Other _________
First Name: ___________________________________ Surname: _________________________________
Date of Birth: _____/______/__________ Occupation: ____
Address:
____
Suburb: ____Post Code: _______________________
Home Ph: __________________________ Mobile: ____
Email____

Medicare No: _______________________ Ref No: ____ Expiry Date: ______________________
Pension Card No: _______________________________ Expiry Date: _______________________
HEALTHCARE CARD NOT ACCEPTED
DVA Card No: ______________________ Expiry Date: ____________
Private Health Insurance: (Please circle) Yes / No
Time with health fund less than 12 months: Yes / No
Fund Name: ________________________________ Membership Number: _____________________

Primary Caregiver/Parent/Emergency Contact/Next of Kin:
Name: ____ DOB: ___________________
Relationship: ________________________Contact No: ______________________________________

Referring Doctor's Name: ____
Clinic: ____
CC: copy to additional doctors: ____
Primary concern to see Doctor: ____

I agree to Dr Eric Levi & Melbourne ENT Airway Clinic passing on my personal details and medical information to other clinicians, hospitals and medical services if necessary for my care. I also consent to the release of health information (including test results, etc) about past and present illness to the doctor making this request. I understand this is necessary for my ongoing treatment.
YES / NO (Please circle)

______________________________	_______________________	________________	_________
Signature of patient or caregiver	**Name**	**Relationship**	**Date**