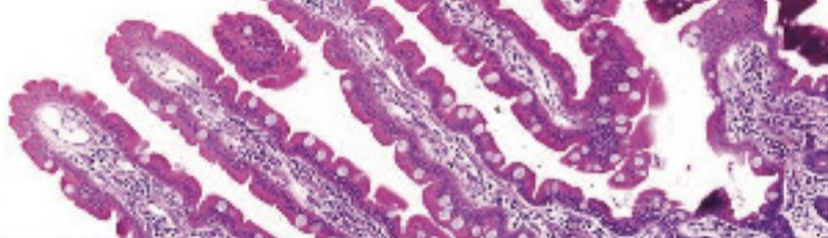


# Dr Paul Froomes

Consultant Physician & Gastroenterologist  
BMedSci MBBS FRACP MD



## CONFIDENTIAL PATIENT REGISTRATION

**Personal Details:**  Mr  Mrs  Ms  Master  Miss  Mx  Other: \_\_\_\_\_

Surname:		Given Name(s):	
Preferred Name:	Date of Birth:	Gender:	
Address:			
State:	Postcode:	Occupation:	
Email:			
Mobile:		Home Phone:	
Emergency Contact Name:			
Contact Number:		Is this your next of kin: <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Referring Doctor Details:

Name of Referring Doctor:	
Contact Number:	Is this your usual GP? <input type="checkbox"/> Yes <input type="checkbox"/> No
Clinic Name/Address:	
Details of usual GP if not your referring doctor:	

### Claim Details:

Medicare No:	Ref No:	Expiry Date:
Name of claimant on Medicare Card:	Ref No:	D.O.B:
Age or Disability Pension No:		Expiry Date:
Healthcare Card No:		Expiry Date:
Veterans Affairs Card Number:		Card Colour:
Do you have Private Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fund Name:	
Membership Number:	Do you have Hospital Cover? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name as displayed on Fund Card/Policy:		

Do you consent to our clinic using and uploading to your My Health Record?  Yes  No

### Fees:

**Initial Consultation: \$350 (Medicare rebate \$137.65)**

**Review Consultation: \$250 (Medicare rebate \$68.90)**

Aged and Disability Pension cardholders  
ONLY will be Bulk Billed.

The personal health information that you provide during your consultation and subsequent treatment will be collected for the purpose of providing high quality health care.

The clinic's policy is to protect your privacy and this information is only disclosed to other members of your treating team where necessary. It will, however, be disclosed to other organisations where required by law or, if necessary, for debt recovery purposes. You may gain access to your personal information held by this office by contacting us in writing. I have read, understood, and agree to the above and I consent to information being released from my medical records as indicated above.

I understand that if I fail to pay an account within the specified period (60 days), my account will then be forwarded to a debt collection agency and additional costs may be incurred.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

For All Appointments - Phone 9331 3122

[www.drpaulfroomes.com.au](http://www.drpaulfroomes.com.au)

#### Consulting at:

- **Main Consulting Rooms:** Suite 4, Level 1, 8 Eddy Street, Moonee Ponds VIC 3039
- **Beingwell Healthcare:** 386 Malvern Road, Prahran VIC 3181