Dr Maurice Guzman
Orthopaedic Surgeon
MBBS(Hons) FRACS FAOrthA

PATIENT REGISTRATION FORM

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Master ☐ Dr

Name _____
as it appears on your medicare card

Address _____

_____
Suburb *Postcode*

Postal Address _____

_____
Suburb *Postcode*

Date of birth _____ / _____ / _____

Phone number _____
Home

_____
Work

_____
Mobile

Do you consent to receiving SMS from us when necessary? ☐ Yes ☐ No

Email Address _____

Medicare number __ __ __ __ __ __ __ __ __ __ __ __ (__) *Expiry* _____ / _____

Private Health Fund _____
Name *Member no.*

Hospital cover ☐ None ☐ Basic ☐ Medium ☐ Top

Pension/HCC number _____
Expiry

Pension type ☐ Age ☐ Disability ☐ Other (please state) _____

DVA number _____
Card colour

Worker's Comp /Third party ☐ Yes ☐ No _____
Claim no.

Dr Maurice Guzman
Orthopaedic Surgeon
MBBS(Hons) FRACS FAOrthA

PATIENT REGISTRATION FORM

Usual GP

Name _____

Practice _____

Address _____

_____

Suburb *Postcode*

Phone Number _____

Next of kin

Name _____

Phone Number _____

Relationship _____

I hereby authorise Dr Maurice Guzman to record notes regarding my medical condition and to supply documents, reports or certificates to Doctors, Solicitors and Insurers, who request the same (as per the attached consent).
I confirm the above details are correct and undertake to pay all fees owing to Dr Maurice Guzman.

_____ _____ / _____ / _____

Patient signature **Date**

Parents, please complete for patients under 18 years of age

Parent's name _____

Parent's date of birth _____ / _____ / _____

Parent's Medicare number __ __ __ __ __ __ __ __ __ __ __ __ __ (__) *Expiry* _____ / _____