Dr Wan Tinn Teh
MBBS FRANZCOG MRMed
Gynaecologist & Fertility Specialist
Provider no. 261893MT

Ph: 1300 926 834
Fax: 1300 834 926

New Patient Registration Form

Personal Details
Title (*Please circle):* Mr Mrs Ms Miss Dr

First name: ______________________________ Surname: ______________________________________

DOB: ____ /____ /________

Address: ________________________________

____

Contact (Home): _______________ (Mobile): _______________________ (Work): _________________

Email: ____

Medicare Card: __ __ __ __ __ __ __ __ __ __ Ref no: __ Exp: __ __ / __ __

Private Health Insurance: ____

Membership no: ____

Partner's Details (if applicable)
Title (*Please circle):* Mr Mrs Ms Miss Dr

First name: ______________________________ Surname: ______________________________________

DOB: ____ /____ /________

Relationship: _______________________________ Contact No: ________________________________

Medicare Card: __ __ __ __ __ __ __ __ __ __ Ref no: __ Exp: __ __ / __ __

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GP Details

Name: ____

Address: ____

Phone: ______________________________ Fax: ______________________________

Fees
Please note that this is a private billing clinic and full payment is required on the day of consultation. If you have any queries about fees, please contact reception prior to your appointment. Additional fees may arise during treatment.

Cancellation
A reminder text will be sent to you prior to your appointment. A cancellation fee may apply if less than 24 hours' notice is given.

Privacy statement

I ____________________________ **(print name)** understand that this medical practice collects my information for the primary purpose of providing quality healthcare. Information I provide may be used for administrative purposes including billing and compliance with Medicare and Health Insurance Commission Insurance requirements. Information may also be sent to other practitioners involved in my care while at other times, information regarding my care may need to be attained from other healthcare providers. Confidentiality will always be maintained if any information related to my care is used in research, quality assurance or educational purposes.

Signature: ____ Date: ____ / ____ / ________