Dr Peter Wein

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MBBS, FRANZCOG, Grad Dip Epidem Biostat
Obstetrician and Gynaecologist
Clinical Associate Professor

Suite 114
320 Victoria Parade
East Melbourne VIC 3002

Tel: 9418 8210
Fax: 9415 1716
Provider Number: 32455BH

E-mail: dr.peterwein@ozemail.com.au
www.drpeterwein.com.au

CONFIDENTIAL PATIENT REGISTRATION FORM

TITLE: Mrs/Ms/Miss/Dr/Other _____ SURNAME:_____

GIVEN NAMES: _____

ADDRESS: _____

SUBURB: _____ STATE: _____ POSTCODE _____

E MAIL ADDRESS: _____

DOB: ____/____/_____ OCCUPATION: _____

TELEPHONE (H) _____ (W) _____ (M) _____

MEDICARE NUMBER: _____ REF: ____ EXPIRES: ____/_____/_____

PRIVATE HEALTH INSURANCE: (put Uninsured if none)_____

MEMBERSHIP NUMBER: _____ REF: ____

HCC/ PENSION CARD NUMBER: _____ EXPIRES: ____/_____/_____

GENERAL PRACTITIONER/ REFERRING DOCTOR: _____

SPOUSE/PARTNER: _____ TELEPHONE: _____

OTHER NEXT OF KIN: _____ RELATIONSHIP: _____ TEL: _____

ALLERGIES: _____

HOW DID YOU HEAR ABOUT DR WEIN? _____

This is a private specialist practice and there is an out-of-pocket cost for consultations. Accounts are payable on the day of consultation. We accept payment by cash, cheque, credit card, or EFTPOS.

We use a debt recovery service for overdue accounts, which will incur additional costs.

The practice has policies concerning privacy and health information. It may be necessary to share personal or medical information with other practitioners who are involved in your care. This is in accordance to the Health Records Act (Vic) 2001 and the National Privacy Principles in the Privacy Act (Australia) 1998.

I acknowledge the above financial and privacy statements:

SIGNED: _____ DATE: ____/_____/_____

Please complete and return prior to your appointment to:
Suite 114/320 Victoria Parade East Melbourne 3002
Or
Fax: 9415 1716
Or
E mail: reception@drpeterwein.com.au