



Dr Michael P Hennessy

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Patient registration details

Title _____ First Names _____ Last Name _____

DOB _____ Home Phone _____ Work Phone _____

Mobile Phone _____ Opt out of SMS Appointment reminders

Address _____

Email address _____ Occupation _____

Next of kin _____ Phone _____ Relationship _____

Family Doctor _____ Address _____

Optometrist _____ Address _____

• Private Health Insurance Fund Name _____ Membership Number _____

• Medicare _____ / _____ / ____ Ref ____ Expiry ____ / ____

• Veterans Card Number _____

• Pension Card Number _____ Expiry ____ / ____

• Workers' Compensation Insurance Company _____ Claim Number _____

How did you hear about us? GP Friend Website Optometrist Other _____

Medications _____

Allergies _____

Prior Eye History _____

Declaration

I have read the Privacy Amendment Act and give permission for correspondence to be sent to my referring doctor, general practitioners, Optometrist and insurance company where appropriate. I consent to Voice messages being left on my answering service.

Opt out of voice messages

I undertake to pay all fees owing to my Surgeon, including in the event that liability is denied or any outstanding accounts that have not been paid in full by my insurer.

I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery fees and I will also be responsible for any legal costs incurred.

Signed by patient or parent/guardian _____ Date _____

Name (Please print) _____

