

Victorian Children's Clinic – Patient Registration Form



**Victorian Children's Clinic**

**Victorian Children's Clinic**  
ABN: 39 364 072 040  
149 Wattleree Road  
Malvern VIC 3144  
T: 03 9509 2244  
F: 03 9509 2833  
victorianchildrensclinic.com.au

Patient's First name: \_\_\_\_\_

Patient's Surname: \_\_\_\_\_

Patient's Pref. Name: \_\_\_\_\_

D.O.B: \_\_\_ / \_\_\_ / \_\_\_ Gender: M  F

Address: \_\_\_\_\_  
\_\_\_\_\_

Medicare No: 

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Expiry date: \_\_\_\_\_ Ref. No: \_\_\_\_\_

Private Health Fund (for eligible services): \_\_\_\_\_ Member #: \_\_\_\_\_

Are there any court orders/custody arrangements for the child? Yes  No

If yes, please provide details or a copy of the court orders with your registration form

**Parent 1:**

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_

Phone (h): \_\_\_\_\_

Phone (w): \_\_\_\_\_

Phone (m): \_\_\_\_\_

**Parent 2:**

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_

Phone (h): \_\_\_\_\_

Phone (w): \_\_\_\_\_

Phone (m): \_\_\_\_\_

**We will email clinical correspondence to you, rather than post, unless you nominate otherwise.**

If you do not wish to have correspondence sent by email, please tick this box

Preferred Email: \_\_\_\_\_ Alternative Email: \_\_\_\_\_

Person responsible for Account\*: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Medicare #: \_\_\_\_\_ Reference #: \_\_\_\_\_ Expiry Date: \_\_\_ / \_\_\_ / \_\_\_

\*Please complete Account Holder details in full. To submit your child's account to Medicare we require their parent/guardian details.

**Referring Doctor Details:**

Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Clinic Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

**Family Doctor Details:** If different to Referrer

Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Clinic Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

I have received a copy, read and understood the Victorian Children's Clinic Privacy and Cancellation Policies.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_