# A logo with text and leaves Description automatically generated Patient Registration Form

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT INFORMATION | | | | | | | | | | | | | |
| First Name:  Last Name: | | | | | Title: | | | | Marital status: | | | | |
| Mr.  Mrs.  Dr. | Miss  Ms.  Master | | | Single  De Facto  Married | | | Divorced  Separated  Widowed | |
| Preferred Name: | | Legal name on Medicare Card: | | | Former name: | | | Date of Birth: | | | Age: | | |
|  | |  | | |  | | |  | | |
| Gender:  male  female  non-binary  transgender  prefer to not say  prefer to self-describe | | | | | | | | | | | | | |
| Are you of Aboriginal or Torres Strait Islander Origin?  Yes  No | | | | | | | |  | | | | | |
| Address: | | | | | Landline: | | | | | | | | |
| Email Address: | | | | | Mobile: | | | | | | | | |
| Occupation: | | | | | Employer: | | | | | | | | |
| Do you hold a current pension/concession/student card?  No  Yes Type:       No. | | | | | | | | | | | | |
| Do you have a current Mental Health Care Plan from a GP?  Yes  No | | | | | | | | | | | | | |
| Your Medicare No:       Expiry Date:       Number beside your name: | | | | | | | | | | | | | |
| Current Medical Conditions (if not listed on referral letter): | | | | | | | | | | | | | |
| Current Medications (if not listed on referral letter): | | | | | | | | | | | | | |
| Do you have any specific needs or impairments that we may need to consider when providing treatment? (e.g. eye problems, hearing impairments, being unable to sit for 60 minutes, or any reading/writing difficulties):  Yes  No | | | | | | | | | | | | | |
| What is the main thing you hope to achieve from psychological treatment? | | | | | | | | | | | | | |
| Would you be interested in low-cost online group therapy?  Yes  No  Maybe | | | | | | | | | | | | | |
| Where did you hear about our service? | | | | | | | | | | | | | |
| PAYMENT DETAILS  *Our processes adhere to current privacy regulations for storing sensitive information securely.*  *Note. You will always be advised of any deductions from your account.* | | | Visa  MasterCard (tick one)  Name on Card:       Card Number:       Expiry Date:       CCV:  I agree for myMHC to store my card details securely for payment of fees (tick) | | | | | | | | | | |
| IN CASE OF EMERGENCY (Must be Completed) | | | | | | | | | | | | | |
| Emergency Contact: | | | | | Relationship to you: | | | | Phone: | | | | |
| Regular Doctor(s): | | | | | Clinic Name: | | | | Phone: | | | | |
| Psychiatrist Name: | | | | | Clinic Name: | | | | Phone: | | | | |
| Do you receive assistance from any other support services or specialists?  Yes  No | | | | | | | | | | | | | |
| WorkCover, TAC, DVA, NDIS & VOCAT Clients ONLY | | | | | | | | | | | | | |
| WorkCover | TAC | | | DVA Card Type | | | VOCAT | | | NDIS | | | |
| Date of Injury / Accident: | | | | | Claim/Card Number: | | | | | | | | |
| Type of Injuries Sustained: | | | | | Approved Injury: | | | | | | | | |
| Who do we send your invoice to? (If workcover, which insurance company?) | | | | | | | | | | | | | |
| Billing Address or Email Address: | | | | | | | | | | | | | |
| Contact Person/Case Manager:       Phone Number: | | | | | | | | | | | | | |
| VOCAT ONLY – Magistrates Court Where Claim Lodged:       Number of Sessions Awarded: | | | | | | | | | | | | | |
| NDIS ONLY- Participant Number:       Plan Manager:       Plan Review Date (if Known): | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Please email this document AND your signed consent form (as well as any referral letters, MHCPs, approval letters, NDIS goals, previous reports etc.) to** [**admin@myMHC.com.au**](mailto:admin@myMHC.com.au) **before your appointment.** | | | | | | | | | | | | | |