CANBERRA Sleep Clinic
ABN 95 083 973 303

Equinox 2
24/70 Kent Street
Deakin ACT 2600
P 02 6282 4955
F 02 6285 1608

NEW PATIENT INFORMATION FORM

Title:			Date of Birth	M / F
First Name:			Occupation	
Last Name:			Ph: (Hm)	
Middle Name:			(Wk)	
Known As:			(Mb)	
Residential Address:			(Fax)	
Suburb:	State:	P/code:	If we need to call you may we identify the surgery at the following numbers	
Postal Address:				
Suburb:	State:	P/code:	Work	Yes / No
Email Address:			Home	Yes / No
☐ Tick this box if you agree to correspondence being sent to your email			Mobile	Yes / No
Next of kin:			SMS	Yes / No

Medicare No: Ref #	Expiry Date:	
Private Health Insurance: Yes / No	Details:	
Pension No:	Expiry Date:	Pension Type:
Veteran's No	Expiry Date:	If White Card – Conditions:

Referring Dr:	Usual GP:
Address:	Address:

Person responsible for payment of accounts:

Do you authorise the Canberra Sleep Clinic to electronically process your Medicare claim on your behalf? Yes / No

I acknowledge the Privacy Policy and agree for correspondence to be sent to my referring doctor, GP and other clinicians involved in my care. I also undertake to pay all fees owing to Canberra Sleep Clinic.

Signed: _____ (Self or Guardian) Date: _____

Workers Compensation & Third Party Only		
Insurance Co	Contact Person	Ph
Date of Injury	Claim No	
Employer	Contact Person	Ph
Employer Address		
Solicitor	Contact Person	Ph
Solicitor Address		

I understand the final responsibility of any accounts for treatment is my responsibility. Should the employer or insurer deny liability, I accept responsibility for payment of any monies due to Canberra Sleep Clinic. Further, I acknowledge that bookings for any procedures will not be made until the surgery has received written confirmation of acceptance by your insurer.

Signed: _____ (Self or guardian) Date: _____