Dr Lay Tay

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Patient Registration Form

Please complete this form and bring it with you to your appointment or return via email to [info@redblood.com.au](mailto:info@redblood.com.au)

|  |  |
| --- | --- |
| Date of Appointment (if known) |  |
| Time of Appointment (if known) |  |
|  |  |
| First Name |  |
| Last Name |  |
| DOB |  |
| Sex - Male/Female |  |
| Address |  |
| Phone – home |  |
| Phone – work |  |
| Phone – mobile |  |
| Email |  |
| Next of kin contact |  |
| Next of kin relationship |  |
| Next of kin phone |  |
| Medicare No. |  |
| DVA No. (if applicable) |  |
| Pensioner/Health care card No. (if applicable) |  |
| Private Health Fund /and Membership No. |  |
| Referring Doctor’s Name |  |
| Referring Doctor’s Provider No. |  |
| Referring Doctor’s Address |  |
| Referring Doctor’s Phone |  |
| Referring Doctor’s Fax |  |
| Date Form Completed |  |