# Patient Registration Form

**DR. KAREN HOLZER**
**SPORTS AND EXERCISE PHYSICIAN**
**MBBS, FACSP, PHD**

Melbourne Sports Physicians

Title: Surname: Given Names:

Date of Birth: Preferred Name:

Residential Address:

Suburb: State: Postcode:

Telephone: Home: Business:

Mobile:

Email address:

Occupation:

Medicare Number: _ _ _ _ _ _ _ _ _ _ Reference No: __ Expiry Date ___/___

Referring Doctor:

GP/Local Doctor[ if not the referring doctor]:

Next of Kin:

Address:

Phone number:

Relationship to patient:

Account details:

Please be advised that the Melbourne Sports Physicians have a fee schedule based on what is fair and reasonable. Patients are reminded that these are beyond the standard rebate provided by Medicare.

The terms of the contract are settlement of the account on the day of consultation.

Payment by EFTPOS, Cash, or Credit [Visa or MasterCard] are available.

Person responsible for the account: Relationship to patient:

Signature of Patient/Guardian: Date: _____/_____/_____