Dr. Myuran Ponnam-Palam
FERTILITY SPECIALIST

Female and Male Infertility

PATIENT REGISTRATION FORM – **PLEASE USE BLOCKED LETTERS**

Title:(tick) ☐Miss ☐Ms ☐Mrs Other:_____ Interpreter Required (tick if yes):☐

Please write name as is on Medicare Card.

Surname: _____ First Name: _____

Middle Name: _____

Status (tick): ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐De Facto

Address: _____

Suburb: _____ Postcode: _____

Date of Birth: _____ Occupation: _____

Telephone (M) _____ (H) _____ (W) _____

Email: _____

Medicare
Card No. : __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Medicare Ref No.
(left of name): __ Expiry Date: _____

Healthcare/Pension Card No: _____ Expiry: _____

Private Health Insurance Name: _____ Policy/Member No:_____

Policy Type: _____ Have you had this longer than a year?_____

Partner / Next of Kin Details- **Please write name as is on Medicare Card.**

Surname: _____ First Name: _____

Relationship: _____ Date of Birth: _____

Telephone *must be different to patient listed above* _____

Email *must be different to patient listed above*_____

Medicare
Card No. : __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Medicare Ref No.
(left of name): __ Expiry Date: _____

How did you hear about Dr Myuran Ponnam-Palam? _____

Please note all accounts are due at the time of consultation