IKH PSYCHOLOGY
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CLIENT REGISTRATION FORM

Identification Information

Title (please circle): Dr Mrs Ms Miss Mr Master Other

Name: ..... Date of Birth: .....

Address: .....

City: ..... Post Code: .....

Phone/Mobile: ..... Email: .....

Medicare & Private Health

Medicare #: ..... Position: ..... Expiry: .....

If child is client:

- Parent/Guardian Full Name : .....
- Medicare # and Expiry if different from child's #..... Expiry: .....
- Position No: .....

Private Health Fund (if relevant): .....

Private Health Fund number (if relevant): .....

(please tick) ☐ Parent ☐ Legal Guardian ☐ Next of Kin ☐ Emergency Contact

Name: ..... Relationship to you: .....

Address: .....

City: ..... Post Code: .....

Contact Numbers: Home: ..... Mobile: .....

Referral Information

Do you have a current Mental Health Plan YES / NO

GP Name: ..... Name of Practice: .....

GP Contact Number & Address: .....

Are you being referred under any other program? (please list program): .....

Other

How did you hear about this service? .....