PATIENT INFORMATION FOR DR CHANG

Title: Mrs/Miss/Ms _____ First Name: _____

Surname: _____ Preferred Name:_____

Address: _____

Date of Birth: _____

Phone: (h) _____ (w) _____ (m) _____

Medicare Number: _____ Reference No:_____

Private Health Fund: _____

Membership No: _____ Reference No: _____

Pension No: _____ (Aged/Disability only)

Referring Doctor: _____

Usual G.P: _____

How were you referred to Dr Chang? □ Local Medical Officer □ Friend □ Other

Occupation: _____

Partner's Name: _____ D.O.B. _____

Next of Kin: _____ Phone: _____

Language Spoken: _____

I understand that should there be any non payment of my accounts Dr Chang may use debt collectors on his behalf to recover outstanding funds and there may be an administration fee applied to this

Signed: _____Date:_____

PATIENT CONSENT:

I _____ give my consent for Dr Chang to collect any necessary medical information on my behalf. I understand that it may be necessary for this information to be passed on to other health care providers.

Signed: _____ Date: _____