Eastern Neurology

DR STEVEN NG
PATIENT REGISTRATION FORM

Surname:……

Given Names:……

Miss ☐ **Mrs** ☐ **Ms** ☐ **Mr** ☐ **Dr** ☐

Date of Birth:……**Occupation:**……...

Address:……

……

Telephone: **(Home)**……**(Work)**……

(Mobile)……...

Medicare No:……**Ref:**……**Expiry:**……

Veterans' Affairs No: VX……

Private Health Fund:……

Membership No:……**Level of Cover:**……..

Workcover Claim No:……..**Insurer:**……...

Case Manager:……...

TAC Claim No: ……**Date of Accident:**……...

Next of Kin:…….....**Relationship:**……..

Contact Nos:……..

List any medical conditions:……

……

List any medications currently taking:……...

……

List any drug allergies:……

Privacy Statement: I agree to allow Dr Ng to pass on my personal details and medical information to other doctors, hospitals and medical services who will be involved in my medical management through his practice or to review my pathology and radiology results with other diagnostic specialists. In the case of surgery to contact my next of kin listed above to provide information regarding my condition.

Charges: All fees must be paid at the time of consultation by Visa, Mastercard or Cash. No personal cheques will be accepted.

Signed:……..**Date:**……

Failure to attend appointments without 48 hrs notice will incur a fee.