

DR STEVEN NG/ DR HUE MUN AU YONG / DR JESSIE CHEN / DR SIMON LI  
EASTERN NEUROLOGY

PATIENT REGISTRATION FORM

Surname:..... Given names:.....

Title: ..... Aboriginal and Torres Strait Islander: Yes/No

Gender: ..... Marital Status: ..... Occupation: .....

Date of Birth:..... Preferred language (if not English): .....

Address:.....

Telephone: (Home).....(Work).....

(Mobile).....(Email).....

Medicare No:.....Ref:.....Expiry:.....

Veterans' Affairs No: .....Concession Card No. ....

Private Health Fund and Membership No.:.....

Workcover Claim No:.....Insurer:.....

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

Next of Kin:..... Relationship:.....

Contact No:.....

GP name (if referred by specialist).....

List any medical conditions (  refer to the referral letter): .....

.....

List any current medications incl. Vitamins (  refer to the referral letter):.....

.....

List any drug allergies:.....

Height:..... Weight:.....

**Agreement:**I agree to allow Eastern Neurology to access and share my personal details and medical information to other health providers who will be involved in my care. In case of emergency to contact my next of kin listed above to provide information regarding my condition. Unless instructed otherwise, I will arrange appointment to follow up my investigation results.

**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.