Dr Ron Chang
MB BS (UQ), M Reprod Med (UNSW) FRANZOG
Obstetrician & Gynaecologist

PATIENT DETAILS

Personal Information:

Title: Miss ☐ Mrs ☐ Ms ☐	Date of Birth: / /
Given Names:	Surname:
Occupation:	Employer:

Contact Information:

Residential Address:		
		Post Code:
Postal Address:		
		Post Code:
Home Ph:	Work Ph:	Mobile Ph:
Email Address:		May we send SMS? Yes ☐ No ☐

Next of Kin:

Name:	Relationship:	
Home Ph:	Work Ph:	Mobile Ph:

Medicare Details:

Card No: _ _ _ _ _ _ _ _ _ _ _	Prefix No: *(Number in front of your name)*	Valid to: _ _ / 20 _ _

Private Health Insurance : Yes ☐ No ☐

Health Fund:	Membership No:	Prefix No:
How long have you been with the Health Fund?		

Veteran Affairs: Yes ☐ No ☐

Card No:	Card Type:

Service Personnel: Yes ☐ No ☐

Regimental No:	Rank:	Unit:

Have you been a patient of this practice before? **Yes ☐ No ☐**
Do we have your permission to contact you with medical results? **Yes ☐ No ☐**

Fees and Payment: The fees charged by this Practice are those recommended by the Australian Medical Association. Consultations are required to be paid for at the time of your visit. If surgery is contemplated, full payment of the surgical fee is required on the day of the operation.

Privacy: I understand this Practice has a privacy policy for handling patient information. The Privacy Statement is on display and can be printed on request. I understand I am not obliged to provide any information to this practice but that it assists in providing quality health care. I have the right to access the information collected about me and I consent to use of this information for health care, administration, medical defence purposes, billing and disclosure to other health care professionals involved in my care.

Signature:	**Date:**