



# SUNNYBANK MEDICAL SPECIALISTS SUITES

Professor Yee Hing Thong

## Personal Information

(Dr/Mr/Mrs/Ms/Miss) Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Country of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Ref No: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

For patients under 18, please provide:

Parents Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medicare Number: \_\_\_\_\_ Ref No: \_\_\_\_\_ Exp: \_\_\_\_\_

## General Practitioners Details

Usual General Practitioner: \_\_\_\_\_

Surgery Address: \_\_\_\_\_

Other Treating Doctors: \_\_\_\_\_

Surgery Address: \_\_\_\_\_

## Medical History:

Drug Allergies: \_\_\_\_\_

Regular Medications: \_\_\_\_\_

I hereby accept responsibility for payment of my account. I give permission for Professor Yee Hing Thong to collect information and if necessary to share information with other Health Practitioners in order to provide optimum treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ALL INFORMATION OBTAINED IS PART OF YOUR PROTECTED MEDICAL RECORD