Dr Michael K Ng MBBS FRACS
ENDOSCOPIC, GENERAL & ENDOCRINE SURGEON

Title Mr / Mrs / Miss / Ms / Dr Surname .....

Given Names .....

Date of Birth .....

Residential Address .....

City ..... State ..... Postcode .....

Postal Address .....

City ..... State ..... Postcode .....

Phone (Home) ..... Phone (Business) ..... Mobile .....

Email .....

Medicare no. ☐☐☐☐ ☐☐☐☐☐ ☐ Ref no. ☐ Expiry ☐☐/☐☐☐☐

Private Health Insurance Y / N Excess to pay Y / N Waiting period served Y / N

Health fund name ..... Membership number .....

Pension no. ..... Expiry .....

Dept Veteran Affairs Gold / White Card no. .....

Workcare or TAC no. ..... Please bring relevant paper work

Referring doctor ..... Name of Usual Doctor .....

Emergency / Next of Kin's name ..... Relationship .....

Contact numbers .....

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 this 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.

Patient Medical History Date of Appointment .....

Patient Name ..... Date of Birth .....

Do you take blood thinning medications Y / N

List of blood thinning medications (if any) .....

Are you diabetic? Y / N If yes, is this controlled by medication/insulin? Y / N

List of diabetic medications (if any) .....

Please list any other regular medications you take below:

Medication	Reason of taking
.....	.....
.....	.....
.....	.....
.....	.....

Are you allergic to latex or rubber? Y / N Are you allergic to anything else? Y / N

Allergy	Type of reaction
.....	.....
.....	.....

List any medical conditions .....

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☐ I understand that if a follow up appointment has been recommended to me that it is my responsibility to attend that appointment or if unable to do so notify the practice or a fee for the appointment will be charged.

Charges : All fees must be paid at the time of consultation by EFTPOS, Visa or MasterCard.

Signed: ..... Date: .....