Dr Wan Tinn Teh
MBBS FRANZCOG MRMed
Gynaecologist & Fertility Specialist
Provider no. 261893MT

Ph: 1300 926 834
Fax: 1300 834 926

新病人登记表

Personal Details 个人资料

Title 称呼 (*Please circle* 请打圈)*:* Mr Mrs Ms Miss Dr

First name 名: _____ Surname 姓: _____

DOB 生日日期 : ____ /____ /_____

Address 住址 :_____

Contact 联系号码 (家) : _____ (手机) : _____ (工作) : _____

Email 电子邮件 : _____

Medicare Card 国民医保卡号码 : __ __ __ __ __ __ __ __ __ __

Ref no 您名字前的号码 : __ Exp 有效日期 : __ __ / __ __

Private Health Insurance 私人医疗保险 : _____

Membership no 私人医保卡号码 : _____

Partner's Details 病人伴侣资料 (if applicable 如适用)

Title 称呼 (*Please circle* 请打圈)*:* Mr Mrs Ms Miss Dr

First name 名: _____ Surname 姓: _____

DOB 生日日期 : ____ /____ /_____

Relationship 与病人关系 : _____ Contact No 联络号码: _____

Medicare Card 国民医保卡号码 : __ __ __ __ __ __ __ __ __ __

Ref no 您名字前的号码 : __ Exp 有效日期 : __ __ / __ __

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GP Details 家庭医生

Name 姓名: _____ Phone 联络号码:_____

Address 地址: _____

Fees 会诊收费

Please note that this is a private billing clinic and full payment is required on the day of consultation. If you have any queries about fees, please contact reception prior to your appointment. Additional fees may arise during treatment.
这是私人专科门诊，门诊费须在会诊当天付清。如果您对费用有任何疑问，请与郑医生的秘书联络。

Cancellation 取消预约

A reminder text will be sent to you prior to your appointment. A cancellation fee may apply if less than 24 hours' notice is given. 若您需要取消预约，请于预约时间前一天联络我们。

Privacy statement 隐私声明

I _____ (print name 姓名) understand that this medical practice collects my information for the primary purpose of providing quality healthcare. Information I provide may be used for administrative purposes including billing and compliance with Medicare and Health Insurance Commission Insurance requirements. Information may also be sent to other practitioners involved in my care while at other times, information regarding my care may need to be attained from other healthcare providers. Confidentiality will always be maintained if any information related to my care is used in research, quality assurance or educational purposes.
我明白郑医生有义务保护我的医疗隐私权。我同意郑医生把我的医疗讯息分享给我的家庭医生和有关的医疗部门，并授权郑医生从有关部门获得我的相关医疗资料。

Signature 签名: _____ Date 日期 : ____ / ____ / _____