Dr Hsiang Chung
MBBS (Hons), MS, FRACS
General Surgeon (Surgical Oncology) and
Head & Neck Surgeon

PATIENT INFORMATION SHEET

Please fill in/circle appropriate responses

Title: Mr/Mrs/Miss/Ms/Dr/Other______________ **SURNAME:** ____

First Name: ____________________________________ **Middle Name(s):** ____

Gender: Male / Female **Date of Birth: (DD/MM/YYYY):** ________ /________ / ___________

Residential Address: ____

Postal Address: ____

Telephone (Mobile):__________________________________ **Home:** _____________________ **Work:** _____________________

Email: ____

Occupation: (Present or past if retired): ____ **RETIRED: YES / NO**

MEDICARE No: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ **Line No:** ____ **Expiry:** ____ ____ / ____ ____

HCC/Pension/DVA No: ____________________________ **Expiry Date** ___________________________ **DVA: Gold / White**

Private Health Insurance Fund Name: _________________________________ **Membership No:** ________________________

Referring Doctor or Hospital Name: ____

Referring Doctor Address: ____

General Practitioner (GP) Name: ____

GP Address: ____

Have you received treatment from Dr Chung previously? YES / NO

Next of Kin: _________________________________**Relationship:** __________________ **Tel:** ______________________________

Workers Compensation Only

Employer Name: ______________________________________ **Date of Injury:** ______________________

Insurance Company: _________________________________ **Claim No:** ___________________________

Medical Information:

Current Medications:

Allergies:

Authority and consent for collection and release of medical information

I give my consent to Dr Hsiang Chung and his practice to:

- Obtain the relevant information related to any consultations, investigations and treatment which I have had or will have with regard to my healthcare.
- Release relevant information related to my consultations, investigations and treatment to another medical practitioner who is or will be involved my medical care.
- I understand I have the right to revoke this authorization in writing at any time, although to do so may be at the detriment of the care I receive from my healthcare providers who would be unable to attain all the information relevant to my treatment

Patient Name: ________________________ **Signature:** _________________________ **Date:** __________

Consent for release of clinical information for teaching or research

I give my consent to Dr Hsiang Chung to release **de-identified** clinical data (including clinical pictures) related to my consultation, results and treatment for the purpose of teaching or medical research. De-identified means such data will not include names, date of birth, contact details (address, phone numbers, email), medical record numbers or any other unique identifying numbers, characteristics or codes. Any clinical pictures will not include the full face or any unique identifying marks on the body.

Patient Name: ________________________ **Signature:** _________________________ **Date:** __________