HEART RHYTHM CLINIC

Dr Han Ling MBBS PhD FRACP FESC

Patient Registration Form

Personal Details			
Title (Mr/Mrs/Ms/Dr)		Preferred name	
First name		Date of birth	- -
Surname		Gender	
Address			
Email			
Mobile no.		Home phone no	
Emergency contact name		Emergency contact no(s)	
Relationship to Patient			
Health Cover Details			
Medicare number	__ __ __ __ __ __ __ __ __ __	Private Health Fund	
Medicare reference	__ (Number in front of your name)	Health Fund number	
Medicare expiry	__ __ / __ __ __ __	Concession card type	
DVA gold card number		Concession card number	
GP Details			
GP name			
GP address			
Referring Doctor Details			
Doctor name			
Doctor address			
Medical Conditions			
Current Medications and Doses			

Medication	Dose

I certify that the above information is correct			
Signature		Date	- -

Please complete this form and forward to the Heart Rhythm Clinic by email, fax or post.
Please contact reception if you have any queries.

03 8560 0535 03 8080 6460 admin@heartrhythmclinic.com.au PO Box 25141, Melbourne VIC 3004