DR ARTHUR TENG MB BS (*Syd*), DipPaed (*NSW*), FRACP
Consultant Paediatrician | Sleep Physician | Provider Number **391637K**

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SYDNEY CHILDREN'S SLEEP DISORDERS CLINIC
Established 1995

Suite 513, Eastpoint Tower
180 Ocean Street Edgecliff 2027
Phone: 9328-2199 Fax: 9328-2297
ALL OTHER ENQUIRIES and after hours: 9382 1210

PATIENT REGISTRATION FORM

CHILD'S SURNAME: _____ **GIVEN NAME**(s): _____

Date of birth: _____ Home phone no: _____

Address: _____

Suburb _____ Postcode: _____

Email: _____

Parent's name (1): _____ Mobile: _____
(if surname is different to your child's please specify here) Work: _____

Parent's name (2): _____ Mobile: _____

Work: _____

Referring Doctor: _____ Phone: _____

Address: _____

Provider number: _____ Date referred: ____/____/____

Local Doctor (if different) _____ Phone: _____

Address: _____

Medicare No: _____ Position: _____ Expiry: _____

Pension No: _____ Type: _____ Expiry:

Private Health Fund: _____ Membership: _____

Drug Allergies: _____ MRN (if applicable): _____

YOU CAN CLAIM YOUR MEDICARE REBATE FROM OUR OFFICE. This means that you pay your account in full at the time of your consultation and our reception staff transmits the claim directly to Medicare. The rebate is paid to you by Medicare by either EFT or cheque. If you would like to receive an EFT payment, please provide complete the details below.

I agree to use Telehealth where appropriate and assign the appropriate Medicare Benefits to the doctor or claim the benefit after payment to the doctor. YES/NO (Please cross out one)

Parent's Name: _____ **Date of birth:** _____

Medicare reference no: _____ (the number next to your name on the Medicare card)

BSB no: _____ **Account no:** _____ **Acct Name:** _____

Appointment date: _____ **Time**: _____ **Doctor**: _____

Privacy note: Reports from this Sleep Clinic are usually sent to the referring doctor, local/family doctor and other clinicians directly involved in your child's care, forming part of your child's medical record. Personal details may be supplied to relevant hospitals and treating doctors only when necessary. Please notify Dr Teng and Associates if you do not consent to this. Dr Teng trains junior and senior doctors and might have observers in the clinic at the time of your consultation. Please notify either Dr Teng or our reception staff if you do not consent to this. Confidentiality is always maintained.

PLEASE COMPLETE THIS FORM AND FAX OR EMAIL TO OUR OFFICE PRIOR TO YOUR APPOINTMENT.
On the day of your appointment, please bring your referral letter and Medicare card. Confidentiality is maintained at all times.