

EREC AID SYSTEM ORDER FORM

Date:/...../.....

PATIENT INFORMATION (please print)

Name
(First) (Last)

Street Address

Suburb

State..... Area Code.....

Telephone No D.O.B

How did you first learn about our system?

REFERRING DOCTOR'S DETAILS

Prescribing Doctor's Name.....

Street Address

State..... Area Code.....

Telephone No Medical Speciality

ORDERING DETAILS

	<u>Amount \$</u>
PRODUCT: Esteem (Manual)	
Esteem (Battery)	
Classic (Manual)	
Postage & Handling	\$7.00
Total	

PATIENT PAYMENT DETAILS - Credit Card Details

Account Name.....

Credit Card Number _ _ _ _ _

Card Type Please Circle **Visa** **Mastercard** Expiry Date:..... CCV No:.....

Amount \$.....-..... Signature

Cheque Details (Make payable to Multi Medical Group)

Account Name.....

Bank Branch

Amount \$.....-.....

Patient Signature

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