



Value Membership Card Enrollment Form

For more information, please contact us at 028-85317899,
or via e-mail at enquiry@parkwayhealth.cn.

To enrol as ParkwayHealth Value Member*, please complete this form and send to our billing staff at the clinic or fax it to 028-85312256 (Chengdu Medical Center).

If you have both an English name and a Chinese name, please put down the name that you will use when you visit our clinic. This helps us to locate your patient record correctly (please use Pinyin for Chinese names).

Family Name	First Name	Middle Name	BirthDay MM / DD / YY	Nationality	Gender
_____	_____	_____	__ / __ / __	_____	M F

E-mail address: _____ Insurance Company: _____

Chengdu Address: _____ Postal Code: _____

Company Name: _____

Office Phone: _____ Fax: _____ Home Phone: _____

FOR FAXED APPLICANTS:** (Fax number: 028 8531 2256)

I authorize the above to charge the following amount to my account: _____

AMEX VISA MASTER JCB Others

Card Number: _____ Expiration Date: _____

Name (Please print clearly): _____

Signature: _____ Date: _____

* Please refer to membership program for detailed benefits, terms and conditions.

** Please note that memberships become effective upon receipt of payment.

For ParkwayHealth Internal Use

MEMBERSHIP INFORMATION:

Membership No.: _____ Enrollment date: _____

Total member(s) enrolled: _____ Expiration date: _____

TRACKING OF SERVICES*:

1.	2.	3.	4.	5.	6.

PAYMENT METHOD: Cash Credit Card

Total Amount Paid: _____ Today's Date: _____

ParkwayHealth Staff Initials: _____

* Please initial your name inside the box after each consultation respectively.