

PERSONAL DETAILS CONFIDENTIAL

 Mr Mrs Master Miss Ms Dr Prof Other

Date of Birth: ____/____/____

■ Surname: _____ Given Name: _____

Address: _____

Suburb: _____ Postcode: _____

Email: _____

Occupation: _____

Education: _____

■ Telephone Numbers: Home: _____

Work: _____ Mobile: _____ Emergency: _____

■ Next of kin details (family member or friend / medical power of attorney)

Name: _____ Relationship to you: _____

Contact number: _____

YOUR GP's DETAILS

■ GP's Name: _____ GP Provider Number: _____

Practice details: _____

Contact number: _____

CLAIM DETAILS

■ Medicare Number: _____ Ref No: _____ Exp Date: _____

 Private Health Insurance: Yes No Fund Name: _____ Fund Number: _____

Concession Cards:

Aged or Disability Pension No: _____ Exp Date: _____

 Dept. Veterans Affairs Card No: _____ White Gold Exp Date: _____

Health Care Card No: _____ Exp Date: _____

 ■ WorkCover Details (If applicable) Is this visit related to a WorkCover injury Yes No

Claim No: _____ Date of Injury: _____

Insurer: _____ Employer: _____

Claims Officer Details

Name: _____ Phone: _____ Fax: _____

■ TAC Details (If applicable): Date of Accident: _____ Claim Number: _____

PLEASE TURN OVERLEAF

For All Appointments:

Ph: (03) 9639 3889 Fax: (03) 9639 3882

Email: info@paulsmithneurosurgeon.com.au

Web: www.paulsmithneurosurgeon.com.au

Victoria Parade Neurosurgery

 Suite 2, Ground Floor
 100 Victoria Parade
 East Melbourne VIC 3002

Also Consulting at:

 Rich River Health Group, Echuca
 Deepdene Surgery, Deepdene
 Epworth Eastern, Box Hill

MEDICAL HISTORY

■ Please list current medications: _____

■ Please list previous surgical procedures: _____

Operation: _____ Year Performed: _____

Operation: _____ Year Performed: _____

Operation: _____ Year Performed: _____

■ Do you take any blood thinning agents (eg warfarin, plavix, aspirin, asasantin)? Yes No

Details: _____

■ Do you have any allergies? Yes No If yes please include details: _____

■ Please indicate if you suffer or have suffered from any of the following:

Deep venous thrombosis (DVT) Yes No Heart Attack Yes No Epilepsy Yes No

Pulmonary embolism (PE) Yes No Open Heart Surgery Yes No Stroke Yes No

Bleeding disorder Yes No Coronary Stent Yes No Migraines Yes No

Tuberculosis/chronic infection: Yes No Angina Yes No Diabetes Yes No

Asthma / COAD Yes No

Other: _____

PRIVACY

All information collected by this practice will be used for providing healthcare. Collection and utilization and storage of this information will be compliant with the 2001 Health Records Act.

I consent to Mr. Paul Smith collecting and storing my health information:

Signature: _____ Date: ____/____/____

Name: *(Please Print)* _____

REFERRAL SOURCE

How did you hear about Mr Paul Smith? Referred by Doctor: GP or Specialist _____

Website – www.paulsmithneurosurgeon.com.au or Royal Australian College of Surgeons (RACS) website

Google Yellow Pages White Pages Personal recommendation: _____

Other: _____

For more information visit: www.paulsmithneurosurgeon.com.au