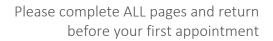


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PERSONAL DETAILS	S	NEW	NEW PATIENT FORM (PAGE 1)			
☐ Mr ☐ Mrs ☐ M	1iss	Prof Other Given Name:	DOB: / /			
Address:						
Suburb:		Postcode:				
Email:		Occupation:				
Phone Numbers:	Home:	Work:				
	Mobile:	Emergency:				
Next of Kin details: (f	amily member or friend / medical	power of attorney)				
Name:		Relationship to	you:			
Contact Number:						
Person Responsible for	or fees: Self Parent Sta	te-trustee 🗌 Other				
Contact details (if not	t self)					
Name:		Address:				
Contact Number:		Email:				
REFERRAL AND PRA	ACTICTIONER					
GP's Name:		GP Provider N	GP Provider Number:			
Practice Details						
Contact Number:						
CLAIM DETAILS						
Medicare Number:		Ref No:	Exp date:			



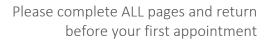


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MEDICAL HISTORY	NEW PATIENT FORM (SIDE 2)
Please list all current medications AND doses: (if include	ded in original referral and correct, there is no
need to re-list)	
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.
MEDICAL HISTORY	
Please list all active medical conditions: (if included in c	original referral and correct, there is no need to
re-list)	
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.
ALLERGIES	
Please list all allergies:	
1.	3.
2.	4.
SURGERIES	
Please list all previous surgeries:	
l	3.
2.	4.

PLEASE TURN OVER AND COMPLETE NEXT PAGE





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CORRESPONDENCE		NEW F	PATIENT FORM (PAGE 3)
Please list any other Health-Care Providers whom you	are seeing, if	you wo	uld like them to receive
correspondence regarding your consults:			
Health-Care Provider 1			
Name:	Location:		
Speciality:	Contact no:		
Health-Care Provider 2			
Name:	Location:		
Speciality:	Contact no:		
Health-Care Provider 3			
Name:	Location:		
Speciality:	Contact no:		
MRI SAFETY			
Please indicate if you have:			
Done any welding, grinding or sheet metal work		YES	NO
2. A cardiac pacemaker or defibrillator		YES	NO
3. A bionic ear / cochlear implant		YES	NO
4. A brain / cerebral aneurysm clip		YES	NO
5. Any metallic surgical implant or foreign bodies		YES	NO
6. A spinal cord or deep brain stimulation device		YES	NO
7. Peripheral nerve stimulation device		YES	NO
8. History of metal fragments in the eye, head or body		YES	NO
9. Shrapnel or gunshot wounds		YES	NO
10. Shunt (spinal or ventricular)		YES	NO
II. Claustrophobia		YES	NO
If you answered 'YES' to any of the above, please list al implantation:	l device serial	numbe	rs, date and location of

PLEASE TURN OVER AND COMPLETE NEXT PAGE



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PRIVACY	NEW PATIENT FORM (PAGE 4)					
All information collected by this practice will be used for providing healthcare. Collection, utilisation and storage of this information will be compliant with the 2012 Health Records Act.						
COMMUNICATION						
Are you happy to receive appointment related information via	email: YES					
Are you happy to receive appointment reminders via SMS:	I ES	5 INO				
FEES						
You have been provided with a Fee Schedule of initial and subsequent consultation fees for in-person, telehealth and telephone appointments.						
 Payment in required on the <u>day of your appointment</u>. If payment presents a problem, please discuss this with practice staff <i>prior</i> to your consultation. For <u>in-person</u> appointments, payment can be made by EFTPOS/credit card, cash or cheque For <u>telehealth/telephone</u> appointments, payment can be made by EFTPOS/credit card (via your patient portal), bank transfer or cheque. Please ask for instructions on patient portal payments. 						
Please provide at least 48hrs notice if you cannot make your appointment. Failure to do this will attract a fail-to-attend fee (50% of attendance). Extenuating circumstances are exempt from this charge.						
CONSENT						
Please sign to confirm that the information provided is accurate, that you agree to our fee terms/payment for your consultation and you consent to The Neuro Group collecting your health information:						
Signature: D	ate:					
Name (please print):						

Please return this form via:
Email – admin@theneurogroup.com.au
Fax - (03) 8676 4926
Mail - PO BOX 293, East Melbourne VIC 3002