THE NEURO GROUP

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Tel: (03) 7019 5531

CONFIDENTIAL INFORMATION

## PERSONAL DETAILS — NEW PATIENT FORM (PAGE 1)

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Master ☐ Dr ☐ Prof ☐ Other DOB: ___ / ___ / _____

**Surname:** **Given Name:**

**Address:**

**Suburb:** **Postcode:**

**Email:** **Occupation:**

**Phone Numbers:** Home: Work:

Mobile: Emergency:

**Next of Kin details:** (family member or friend / medical power of attorney)

Name: Relationship to you:

Contact Number:

**Person Responsible for fees:** ☐ Self ☐ Parent ☐ State-trustee ☐ Other

Contact details (if not self)

Name: Address:

Contact Number: Email:

## REFERRAL AND PRACTICTIONER

**GP's Name:** 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 included 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 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:**

1. _____ 3. _____
2. _____ 4. _____

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## CORRESPONDENCE — NEW PATIENT FORM (PAGE 3)

**Please list any other Health-Care Providers whom you are seeing, if you would 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:**

| | |
|---|---|
| 1. 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 ☐ |
| 11. Claustrophobia | YES ☐ NO ☐ |

If you answered 'YES' to any of the above, please list all device serial numbers, date and location of implantation: _____

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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 ☐ NO ☐

Are you happy to receive appointment reminders via SMS: YES ☐ NO ☐

## 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 day of your appointment**. If payment presents a problem, please discuss this with practice staff *prior* to your consultation.

- **For in-person appointments,** payment can be made by EFTPOS/credit card, cash or cheque
- **For telehealth/telephone 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:** _____ **Date:** _____

**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