Please complete ALL pages and return before your first appointment

www.harpneurology.com.au
Tel: 03 9851 6323

CONFIDENTIAL INFORMATION

PERSONAL DETAILS

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

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

Address: .....

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

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

Phone Numbers: Home: ..... Work: .....

Mobile: ....

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

REFERRAL AND PRACTITIONER

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 No: .....

Concession Cards

Aged or Disability Pension No: ..... Exp date: .....

Dept. Veterans Affairs Card No: ..... ☐ WHITE ☐ GOLD Exp date: .....

Health Care Card No: ..... Exp date: .....

www.harpneurology.com.au
Tel: 03 9851 6323

CONFIDENTIAL INFORMATION

MEDICAL HISTORY

Please list all current medical conditions: (if included in original referral and correct, there is no need to re-list)

1. 5.
2. 6.
3. 7.
4. 8.

Please list all current medications AND doses: (if included in original referral and correct, there is no need to re-list)

1. 5.
2. 6.
3. 7.
4. 8.

Please list all allergies:

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

Please list any previous surgeries

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

Have you ever had botulinum toxin (Botox or Dysport) therapy before? ☐ YES ☐ NO

If Yes, what was the date of your last treatment: ___ / ___ / _____

www.harpneurology.com.au
Tel: 03 9851 6323

CONFIDENTIAL INFORMATION

Please list any other Doctors you are seeing:

Doctor 1

Name: ..... Specialty:

Contact Number: ..... Location: .....

Doctor 2

Name: Specialty: .....

Contact Number: ..... Location: .....

Doctor 3

Name: ..... Specialty: .....

Contact Number: ..... Location: .....

MRI SAFETY CHECK

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

www.harpneurology.com.au
Tel: 03 9851 6323

CONFIDENTIAL INFORMATION

PRIVACY

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

COMMUNICATION

What type of appointment would you prefer:

☐ In-person ☐ Video-conference ☐ Telephone

Are you happy to receive appointment related information via email: ☐ YES ☐ NO

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

CONSENT

Please sign to confirm that the information provided is accurate and you consent to Harp Neurology collecting my health information:

Signature: **Date:**

Name (please print): .....