CLINICAL NEUROLOGY SERVICES

Patient Information

Patient Personal Details

Name:

DOB:

Address:

Mobile:

Email:

Next of Kin : Name : ..... **Telephone:**.....

Do you authorise your next of kin access to your medical records?	**YES**	**NO**
Do you authorise your next of kin to schedule or cancel appointments?	**YES**	**NO**
Do you authorise your next of kin to access financial information regarding your account?	**YES**	**NO**
Do you consent to SMS Reminders for appointments?	**YES**	**NO**
Do you consent for your consultation information to be uploaded to your MyHealth Record?	**YES**	**NO**
Are you Aboriginal or Torres Strait Islander?	**YES**	**NO**

MEDICARE AND / OR CONCESSION CARD DETAILS

Medicare number:

Number next to you name: **Expiry date:**

Veterans Affairs number : **Expiry date :**

Pension Card Number : **Expiry date :**

Healthcare Card Number: **Expiry date :**

Your Usual General Practitioner:

Practice Address :

Previous Neurologists seen

Practice Address:

I provide consent for Dr Darshan Ghia to collect, use and disclose my personal information as described by the principles of the Privacy Act 1988 (details are available from reception). I understand that information about me (including eye images, and test results) may form part of professional educational, audit, or research activities. This information is securely stored within our practice in accordance with our privacy policy. Identifiable information about me, however, will not be disclosed publicly with-out further consent.

I understand unpaid Workers Compensation or MVIT claims will be my responsibility to pay. I also acknowledge that unpaid accounts requiring the services of a debt collector will incur an additional charge. As a current doctor's or optometrist's referral is required for my full Medicare re-imbursement, I understand that it is my responsibility to keep my referral up to date.

Signature : ..... Date :.....

Medical Information

Your allergies to any medications

Medication: What happens if you take this medication?

Other allergies:

Medications you are taking

Name of medicines: Why do you take this medicine?

List any current and/or previous illnesses or medical problems:

List your previous operations/admissions to hospital: