CLINICAL NEUROLOGY SERVICES

Patient Information

Patient Personal Details

Name: **DOB :**

Address :

Mobile :

Email address (personal):.....

<u>Parent/Guardian (details required for invoice)</u>

First Name: ..... **Surname**.....

DOB:: ...../...../..... **Relation to patient:**.....

Medicare number :
Number next to your name : **Expiry date :**

DO YOU:

Consent to the use of SMS Reminders for appointments? **YES** **NO**

Consent for your consultation data to be uploaded to your MyHealth Record? **YES** **NO**

Are you Aboriginal or Torres Strait Islander? **YES** **NO**

<u>MEDICARE AND/OR CONCESSION CARD DETAILS</u>

Medicare number :
Number next to patient name : **Expiry date :**

Healthcare Card Number :
Expiry date :

<u>PRIVATE HEALTH INSURANCE</u>

Name of Fund: **Hospital cover? YES NO**

Family Doctor/General Practitioner (if different from the referring practitioner):

Practice Address :

Previous Neurologists seen

Practice Address:

MEDICAL HISTORY:

Early Child History: Child born at _____weeks/gestation/birth weight

Were there complications during the PREGNANCY?_____

Were there complications during the DELIVERY?_____

Were there complications during the NEW BORN PERIOD?_____

Is there a FAMILY HISTORY of any significant medical condition? (Please state condition and relationship)

Epilepsy

Migraine

Learning difficulties

Muscle disorders

Other

CURRENT MEDICATIONS

Vitamins/Minerals supplements?

Allergies?

MOTHERS NAME:

Address (if different from above):

Phone number: **Date of Birth:**

FATHERS NAME:

Address (if different from above):

Phone number: **Date of Birth:**

OTHER CHILDREN (please list name and date of birth):

PRIVACY ACT

Access can be denied where:

- to provide access would create *a* serious threat to life or health;
- there is a legal impediment to access;
- the access would unreasonably impact on the privacy of another;
- your request is frivolous;
- the information relates to an anticipated or actual legal proceedings and you would not be entitled to access the information in those proceedings; and
- in the interests of national security

A request for Medical information may be denied at the discretion of treating doctor.

Your request must be in writing with permission **in writing from patient if 12 years or over & over, (if they are able to provide permission)**. An administration fee may be charged for photocopying or for staff time Involved in processing your request. Where you dispute the accuracy of the information we have recorded you are entitled to correct that information in writing.

It is our practice policy that we will take all steps to record all of your corrections, and place them with your file but will not erase the original record.

A request for Medical information may be denied at any time at the discretion of treating doctor.

Consent to be provided by patient if 12 years & over, if capable of understanding.

I provide consent for Dr Twinkle Ghia and staff to collect, use and disclose my/my childs personal information as outlined above.

I understand that I am entitled to access my childs records **(MUST BE IN WRITING with permission in writing from the patient if 12 years & over, and if they are able to provide permission)** except where access would be denied as outlined above.

I understand that I may withdraw my consent **(MUST BE IN WRITING with permission in writing from the patient if 12 years & over, and if they are able to provide permission)** as to use and disclose of my personal information (except when legal obligations must be met).

CO SIGNATURE WHERE POSSIBLE BY PATIENT IF OVER AGE OF 12 YEARS:

SIGNED:_____(PARENT GUARDIAN) DATE:___/___/___

SIGNED:_____(PARENT GUARDIAN) DATE:___/___/___

SIGNED:_____(PATIENT) DATE:___/___/___

PATIENTS NAME: _____