PRECISION
HEALTH SOLUTIONS

PRECISION NEUROSURGERY ☐ PRECISION NEUROLOGY ☐ PRECISION HEADACHE CLINIC ☐ PRECISION SPINE & Pain Clinic ☐ PRECISION PSYCHOLOGY ☐

NEW PATIENT REGISTRATION

Please complete this form in blue or black pen only.

TITLE: PROF / DR / MR / MRS / MS / MISS (please circle)

SURNAME: ..... GIVEN NAMES: .....

ADDRESS: .....

SUBURB: ..... STATE: ..... POSTCODE: .....

DOB: ..... AGE: ..... MALE or FEMALE (please circle)

OCCUPATION: ..... LEFT or RIGHT-HANDED (please circle)

EMAIL ADDRESS: .....

TELEPHONE

Home: ..... Mobile: ..... Work: .....

NEXT OF KIN: .....

Relationship: ..... Telephone: .....

REFERRING DOCTOR: .....

Address: .....

Telephone: ..... Fax: .....

GP (if not referring doctor): .....

Address: .....

Telephone: ..... Fax: .....

MEDICARE NUMBER: ..... Reference: ..... Expiry Date: .....

PRIVATE INSURANCE FUND: .....

Membership Number: ..... Level of Cover: .....

VETERAN AFFAIRS: Gold / Blue / White (please circle) VX Number: .....

AGED PENSION NUMBER: ..... Expiry Date: .....

WORK COVER INSURER: .....

Claim Number: ..... Contact Person: .....

Telephone: ..... Fax: .....

EMPLOYER:

Employer Address: .....

Employer's Telephone: ..... Employer's Fax: .....

MAIB: .....

Claim Number: ..... Contact Person: .....

Telephone: ..... Fax: .....

PLEASE INDICATE IF YOU TAKE THE FOLLOWING MEDICATIONS: (please circle)

1. Aspirin	YES / NO
2. Warfarin	YES / NO
3. Plavix	YES / NO
4. Clopidogril or other antiplatelet or blood thinning medications	YES / NO

CURRENT MEDICATIONS YOU ARE TAKING:

NAME	DOSE	FREQUENCY
1.	.....	.....
2.	.....	.....
3.	.....	.....
4.	.....	.....
5.	.....	.....
6.	.....	.....
7.	.....	.....
8.	.....	.....

PLEASE INDICATE IF YOU TAKE THE FOLLOWING HERBAL SUPPLEMENTS/REMEDIES: (please circle)

1. Chamomile	YES / NO	5. Garlic	YES / NO
2. Feverfew	YES / NO	6. Ginger	YES / NO
3. St. John's Wort	YES / NO	7. Ginko Biloba	YES / NO
4. Ginseng	YES / NO		

PLEASE LIST ANY ALLERGIES YOU HAVE:

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PLEASE INDICATE IF YOU SUFFER / HAVE HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS: (please circle)

1. High Blood Pressure	4. Heart Attack	7. Angina	10. Asthma
2. Open Heart Surgery	5. Cardiac Stent	8. Stroke / TIA	11. Diabetes
3. Chronic Infection	6. Migraines	9. DVT / PE	12. Notifiable Disease

Other: .....

PLEASE LIST ANY PREVIOUS SURGERY:

DATE	SURGERY	SURGEON	COMPLICATIONS
1.	.....	.....	.....
2.	.....	.....	.....
3.	.....	.....	.....
4.	.....	.....	.....
5.	.....	.....	.....

PLEASE LIST ALL OTHER DOCTORS YOU ARE SEEING:

NAME	LOCATION	PHONE NUMBER	SPECIALITY EG: GP, Neurology, Osteopath, Chiropractor, etc...
1.	.....	.....	.....
2.	.....	.....	.....
3.	.....	.....	.....
4.	.....	.....	.....
5.	.....	.....	.....

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

I understand that payment of my account is my responsibility and that my health fund / medicare / insurer may not cover the total amount invoiced. I am responsible for any further costs that might be incurred resulting from my not paying my account, in full, by the due date.

I have read and acknowledge the fee payment schedule.

I understand that details of my medical condition(s) may be revealed to other medical and paramedical practitioners, for the purpose of optimising my treatment.

I give permission for information relating to my medical condition(s) and treatment to be used for research and audit purposes. When this is done, I understand that my identity will be protected.

SIGNED: .....

DATE: .....

PRECISION HEALTH SOLUTIONS
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