












## 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:**

.....

.....

**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:** .....