PAUL SMITH
NEUROSURGEON

Please complete **BOTH SIDES** and return to
Victoria Parade Neurosurgery before your first appointment

Mr Paul Smith MBBS FRACS PhD GDEB
Brain and Spine Specialist
Ph: (03) 9639 3889

CONFIDENTIAL

PERSONAL DETAILS — NEW PATIENT FORM (Side 1)

☐ Mr ☐ Mrs ☐ Master ☐ Miss ☐ Ms ☐ Dr ☐ Prof ☐ Other **Date of Birth:** _____/_____/_____

- **Surname:** _____ **Given Name:** _____

Address: _____

Suburb: _____ **Postcode:** _____

Email: _____

Occupation: _____

- **Telephone Numbers:** Home: _____

Work: _____ Mobile: _____ Emergency: _____

- **Next of kin details** (family member or friend / medical power of attorney)

Name: _____ Relationship to you: _____

Contact number: _____

YOUR GP's DETAILS

- **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 Number: _____
- **Concession Cards:**

Aged or Disability Pension No: _____ Exp Date: _____

Dept. Veterans Affairs Card No: _____ ☐ White ☐ Gold Exp Date: _____

Health Care Card No: _____ Exp Date: _____

- **WorkCover Details (If applicable)** Is this visit related to a WorkCover injury ☐ Yes ☐ No

Claim No: _____ Date of Injury: _____

Insurer: _____ Employer: _____

Claims Officer Details

Name: _____ Phone: _____ Fax: _____

- **TAC Details (If applicable):** Date of Accident: _____ Claim Number: _____

PLEASE TURN OVERLEAF AND COMPLETE BOTH SIDES

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MEDICAL HISTORY — NEW PATIENT FORM (Side 2)

- **Please list current medications:** _____

_____

- **Please list previous surgical procedures:** _____

Operation: _____ Year Performed: _____

Operation: _____ Year Performed: _____

Operation: _____ Year Performed: _____

_____

- **Do you smoke cigarettes?** ☐ Yes ☐ No If so how many and for how long? _____
- **Do you take any blood thinning agents (eg warfarin, plavix, aspirin, asasantin)?** ☐ Yes ☐ No

Details: _____

- **Do you have any allergies?** ☐ Yes ☐ No If yes please include details: _____

_____

- **Please indicate if you suffer or have suffered from any of the following:**

Deep venous thrombosis (DVT)	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Pulmonary embolism (PE)	☐ Yes ☐ No	Open Heart Surgery	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	Coronary Stent	☐ Yes ☐ No	Migraines	☐ Yes ☐ No
Tuberculosis/chronic infection:	☐ Yes ☐ No	Angina	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Asthma / COAD	☐ Yes ☐ No				

Other: _____

PRIVACY

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

I consent to Mr Paul Smith collecting and storing my health information:

Signature: _____ **Date:** ___/___/_____

Name: *(Please Print)* _____

REFERRAL SOURCE

How did you hear about us? Referred by Doctor: ☐ GP or ☐ Specialist _____

☐ Our Website ☐ or Royal Australian College of Surgeons (RACS) website

☐ Google ☐ Yellow Pages ☐ White Pages ☐ Personal recommendation: _____

☐ Other: _____

All Appointments, Enquiries & Correspondence:

[Form Last Updated July 18, 2016]

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Also Consulting at:
Rich River Health Group, Echuca
Deepdene Surgery, Deepdene
Wimmera Medical Centre, Horsham

FRACS
Fellow of the
Royal Australasian College of Surgeons