



JEREMY RUSSELL
NEUROSURGEON

Please complete ALL pages and return to Advanced Neurosurgery before your first appointment

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CONFIDENTIAL INFORMATION

PERSONAL DETAILS

NEW PATIENT FORM (SIDE 1)

Mr Mrs Miss Ms Master Dr Prof Other

DOB: ____ / ____ / ____

Surname: _____ **Given Name:** _____

Address: _____

Suburb: _____ **Postcode:** _____

Email: _____ **Occupation:** _____

Phone Numbers: Home: _____ **Work:** _____

Mobile: _____ **Emergency:** _____

Next of Kin details: (family member or friend / medical power of attorney)

Name: _____ Relationship to you: _____

Contact Number: _____

Person Responsible for fees: Self Parent Workcover TAC Veteran's Affairs Other

REFERRAL AND PRACTITIONER 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 No: _____

Concessions 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:** _____

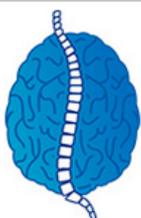
Claim Officer Details: _____ **Name:** _____

Phone: _____ **Fax:** _____

TAC Details (if applicable)

Date of Accident: _____ **Claim No:** _____

PLEASE TURN OVER AND COMPLETE NEXT PAGE



ADVANCED NEUROSURGERY

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Also consulting at:
Cabrini Malvern, The Valley Private
Hospital, Warringal Private,
Peninsula Private, Austin Hospital,
Monash Medical Centre



FRACS
Fellow of the
Royal Australasian College of Surgeons

MEDICAL HISTORY

NEW PATIENT FORM (PAGE 2)

Please List all current medications:

.....

.....

Do you take any blood thinning agents? (eg. Asprin, Asasantin, Plavix, Warfarin, Pradaxa, Xarelto)

YES NO Details:

Do you have any allergies? YES NO

Details:

Do you smoke cigarettes: YES NO

If yes, how many and for how long?

Please list previous surgical procedures and date:

Operation:

Operation:

Please indicate if you have suffered any of the following:

Angina	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Attack	<input type="checkbox"/> YES <input type="checkbox"/> NO
Asthma/ COAD	<input type="checkbox"/> YES <input type="checkbox"/> NO	Migraines	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bleeding disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Open heart surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO
Coronary stent	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pulmonary embolism	<input type="checkbox"/> YES <input type="checkbox"/> NO
Deep vein thrombosis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis/ chronic infection	<input type="checkbox"/> YES <input type="checkbox"/> NO
Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Other :			

PRIVACY

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

I consent to Mr Jeremy Russell collecting my health information:

Signature:

Date:

Name : (please print)

REFERRAL SOURCE

How did you hear about us?

Referred by Doctor : GP Specialist
 Our Website Google Healthshare Personal recommendation
 Royal Australasian College of Surgeons (RACS) website Other