DR MARGUERITE HARDING – Neurosurgeon

ADELAIDE Neurosurgery Centre

PATIENT CONFIDENTIAL INFORMATION FORM

PLEASE COMPLETE THIS PRIOR TO YOUR APPOINTMENT AND BRING WITH YOU ON THE DAY.

PERSONAL DETAILS

Surname Given Name

Address

Suburb Postcode

Email Date of Birth

Occupation

Telephone Home ( ) Work ( ) Mobile

Next of kin:

Name Relationship

Contact Number

GP DETAILS *(please tell reception if differs from referring doctor)*

Name

Address

Suburb Postcode

CLAIM DETAILS

Medicare no. Ref no. Exp Date

Private Health Insurance

Fund Name Fund Number

CONCESSION CARDS

Aged Pension Card no Exp date

Veterans Affairs no ○ White ○ Gold Exp date

WORK COVER DETAILS – *If Applicable*

Name of Insurer

Address of Insurer

Contact no Fax

Email

Case Manager

Claim no Date of Injury

Name of Employer

CONSULTING AT: Level 5, 120 Angas Street Adelaide SA 5000
T (08) 7231 9974 | F (08) 8227 1716 | E admin@neurosurgerycentre.com | neurosurgerycentre.com

DR MARGUERITE HARDING – Neurosurgeon

ADELAIDE Neurosurgery Centre

PATIENT CONFIDENTIAL INFORMATION FORM

PRIVACY INFORMATION

I understand that some of this information will be provided to Medicare as part of the billing and medical rebate process. It may also be used for providing information to your private health fund where appropriate. Information about your medical condition will also be passed on to your referring doctor/general practitioner, and other relevant practitioners or medical bodies in accordance with your consultation. At all times your personal details and medical history are confidential between you and your doctor and will not be released to anyone else including family members without your consent.
(For more details please ask reception or see website)

Signature Date

REFERRAL SOURCE

How did you hear about us?

Referred by doctor: ○ GP ○ Specialist ○ Our website ○ RACS Website ○ Google ○ Personal Recommendation

Other

MEDICAL HISTORY

Do you smoke? ○ Yes ○ No ○ Previously

Do you consume alcohol? ○ Yes ○ No If yes, how much?

Do you suffer from any of the following?

- High blood pressure ○ Yes ○ No
- Diabetes ○ Yes ○ No
- Heart disease ○ Yes ○ No
- Lung complaints ○ Yes ○ No
- Stomach complaints ○ Yes ○ No
- Bleeding disorder ○ Yes ○ No
- Deep vein thrombosis ○ Yes ○ No
- Pulmonary embolism ○ Yes ○ No

Other major illnesses/complaints?

If yes, please specify

Do you have any allergies? ○ Yes ○ No

If yes, please specify

Weight Height

In one sentence – tell me what is the main reason for the consult today?

Describe how your symptoms are affecting your life.

CONSULTING AT: Level 5, 120 Angas Street Adelaide SA 5000
T (08) 7231 9974 | F (08) 8227 1716 | E admin@neurosurgerycentre.com | neurosurgerycentre.com