Dr Linda Dalic
Neurologist

Please complete ALL pages and return before your first appointment

www.drlindadalic.com.au
Tel: 0492 898 504

CONFIDENTIAL INFORMATION

PERSONAL DETAILS — NEW PATIENT FORM (PAGE 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 ☐ State-trustee ☐ Other

Contact details (if not self)

Name: _____ Address: _____

Contact Number: _____ Email: _____

REFERRAL AND PRACTICTIONER

GP's Name: _____ GP Provider Number: _____

Practice Details _____

Contact Number: _____

CLAIM DETAILS

Medicare Number: _____ Ref No: _____ Exp date: _____

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MEDICAL HISTORY NEW PATIENT FORM (SIDE 2)

Please list all current medications AND doses: (if included in original referral and correct, there is no need to re-list)

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

MEDICAL HISTORY

Please list all active medical conditions: (if included in original referral and correct, there is no need to re-list)

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

ALLERGIES

Please list all allergies:

1. _____ 3. _____
2. _____ 4. _____

ALLERGIES

Please list all previous surgeries:

1. _____ 3. _____
2. _____ 4. _____

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CORRESPONDENCE — NEW PATIENT FORM (PAGE 3)

Please list any other Health-Care Providers whom you are seeing, if you would like them to receive correspondence regarding your consults:

Health-Care Provider 1

Name: _____ Location: _____

Speciality: _____ Contact no: _____

Health-Care Provider 2

Name: _____ Location: _____

Speciality: _____ Contact no: _____

Health-Care Provider 3

Name: _____ Location: _____

Speciality: _____ Contact no: _____

MRI SAFETY

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 ☐

If you answered 'YES' to any of the above, please list all device serial numbers, date and location of implantation: _____

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PRIVACY NEW PATIENT FORM (PAGE 4)

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

COMMUNICATION

Are you happy to receive appointment related information via email: YES ☐ NO ☐

Are you happy to receive appointment reminders via SMS: YES ☐ NO ☐

CONSENT

Please sign to confirm that the information provided is accurate and you consent to Dr Linda Dalic collecting your health information:

Signature: _____ Date: _____

Name (please print): _____

Please return this form via:
Email - contact@drlindadalic.com.au
Fax - (03) 8676 4926
Mail - PO BOX 293, East Melbourne VIC 3002