

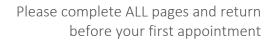
Please complete ALL pages and return before your first appointment

www.drlindadalic.com.au

Tel: 0492 898 504

## **CONFIDENTIAL INFORMATION**

PERSONAL DETAILS		NEW	PATIENT FORM (PAGE I)	
☐ 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	o you:	
Contact Number:				
Person Responsible for fees: Self Parent State-trustee Other				
Contact details (if not	t self)			
Name:		Address:		
Contact Number:		Email:		
REFERRAL AND PRA	ACTICTIONER			
GP's Name:		GP Provider N	Number:	
Practice Details				
Contact Number:				
CLAIM DETAILS				
Medicare Number:		Ref No:	Exp. date:	





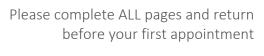
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MEDICAL HISTORY	NEW PATIENT FORM (SIDE 2)			
Please list all current medications AND doses: (if included in original referral and correct, there is no				
need to re-list)				
l	7.			
2.	8.			
3.	9.			
4.	10.			
5.	11.			
6.	12.			
MEDICAL HISTORY				
Please list all active medical conditions: (if included in c	original referral and correct, there is no need to			
re-list)				
l	7.			
2.	8.			
3.	9.			
4.	10.			
5.	H			
6.	12.			
ALLERGIES				
Please list all allergies:				
1.	3.			
2.	4.			
ALLERGIES				
Please list all previous surgeries:				
1.	3.			
2.	4.			

PLEASE TURN OVER AND COMPLETE NEXT PAGE





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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:

correspondence regarding your consults:				
Health-Care Provider 1				
Name:	Location:			
Speciality:	Contact no:			
Health-Care Provider 2				
Name:	Location:			
Speciality:	Contact no:			
·	Gontale No.			
Health-Care Provider 3				
Name:	Location:			
Speciality:	Contact no:			
MRI SAFETY				
Please indicate if you have:				
I. 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 🗆			
II. Claustrophobia	YES 🗆 NO 🗆			
If you answered 'YES' to any of the above, please list all device serial numbers, date and location of				
implantation:				

PLEASE TURN OVER AND COMPLETE NEXT PAGE



Mail - PO BOX 293, East Melbourne VIC 3002

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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:	TES LI NO LI			
CONSENT				
Please sign to confirm that the information provided is accurate and you consent to Dr Linda Dalic collecting your health information:				
Signature: D	Pate:			
Name (please print):				
Please return this form via:				
Email - contact@drlindadalic.com.au				
Fax - (03) 8676 4926				