*Dr Ellison Stephenson abides by the Privacy Act. Information supplied by you is strictly private and confidential and will assist us in providing the best possible care for you. Please complete **ALL** sections.*

Surname _____ First Name _____ Title _____

Address _____

Date of Birth _____ Age _____

Sex _____ Next of Kin _____ **Relationship:** _____

Home Phone _____ _____ NOK contact # _____

Mobile _____ Work Phone _____

Medicare # _____ Ref # _____ Expiry Date _____

Private Medical Insurance Fund _____ Membership # _____

Aged Pension _____ Expiry date _____

Veteran Affairs # _____ Card Type _____

Your regular GP GP Location _____

Your referring doctor _____ Location _____

Urgent Alerts: (*eg pace maker – Aspirin)* .....

This section is for office use only

Date	Procedure

Thank you for your time ☺

Dr Ellison Stephenson abides by the Privacy Act. Information provided by you is strictly private and confidential and will assist us in providing the best possible care for you.

I hereby give consent to staff of this neurosurgical practice collecting and recording such information as is deemed necessary to provide me with medical care. Should referral to other agencies be required I understand that such agencies are also bound by the Privacy Act and I therefore consent to the disclosure of information as is necessary to provide for my care. I understand that this consent may be withdrawn on my written request at any time. I understand that information may be used for education and research in a de-identified manner.

I recognise that I may need to be contacted, my preferred methods of contact include:-
please tick
☐ home ☐ work ☐ mobile ☐ Next of kin (as identified on page 1)

A message can be left on these numbers ☐ yes ☐ no

I understand that I am seeing Dr Stephenson in a private practice clinic and my consultations costs are ultimately the responsibility of myself (DVA excluded).

I, Client_FullName provide the following information to the best of my knowledge. I also confirm that this appointment is for treatment only and no report is to be requested for the purpose of medicolegal or third party insurance (*your referring doctor will receive correspondence from Dr Stephenson following your consultation)*

Signature ……..…. Date ……../……/ ……

Please take a few moments to answer a number of questions regarding your general health. This information will assist Dr Stephenson with your treatment.

Current Medication: ……..……

……..……..

……..……..

Are you taking **Aspirin** or any **blood thinning** medication? ☐ Yes ☐ No

Do you have a **pacemake**r? ☐ Yes ☐ No

Allergies (please list) ……..……..

Past Medical History	No (*please* √)	Yes (*please* √)	If yes, year diagnosed
Lung disease (including pneumonia)			
High blood pressure			
Heart disease			
Kidney disease			
Diabetes			
Epilepsy			
Other, please state.			

Please list any operations you have had

_____ year _____
_____ year _____
_____ year _____
_____ year _____

Are you right or left handed? Left / Right Please circle

Occupation:……

Marital Status - married/defacto ☐ separated/divorced ☐ single ☐ widowed ☐

Hobbies/interests: _____

Thank you for your time ☺