Neuro NSW
Brain & Spine Specialists

Mr / Mrs / Ms / Miss (please circle)

First name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: __ __ / __ __ / __ __ __ __

Gender: Female / Male / Unspecified (please circle)

Mobile: _____ Would you like to receive SMS reminders? Yes / No

Home number: _____ Work number: _____

Email: _____

Residential Address: _____

Suburb: _____ Postcode: _____

Postal Address: (If different from residential)_____

_____

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Exp: __ __ / __ __ __ __ Ref # ___ (this is the number next to your name on your card)

DVA number: _____ Card Type: White / Gold / Orange Exp: __ __ / __ __ __ __

Conc card (Pension/Healthcare Card): _____ Exp: ____/____/____

Occupation: _____

Indigenous Status: Aboriginal / Torres Strait Islander / Neither (please circle)

GP's Name: _____Clinic:_____

Next of Kin Name: _____Contact:_____ Relationship: _____

Do you give permission to contact your next of kin if required? YES / NO

PATIENT CONSENT TO SHARE INFORMATION

Your personal and health information will be held electronically, used and disclosed in accordance with the National Privacy Principles and Health Privacy Principles NSW.

I _____, authorise Dr Sue Baumann to:
Print Name

- *Collect my personal and medical information from providers associated with my health care, including but not limited to; up to date personal information, referrals, medical condition/s, diagnosis, treatment, history, medication/s, reports and results of investigations. These providers include, the referring medical practitioner, other medical practitioners, health care providers, hospitals, insurance & Medico Legal companies, WorkCover insurers and their agents.*
- *Disclose my personal and medical information to providers associated with my health care, including but not limited to; my medical condition/s, diagnosis, treatment, history, medication/s, details of consultations and results of investigations. These providers include, the referring medical practitioner, other medical practitioners, health care providers, hospitals, insurance & Medico Legal companies, WorkCover insurers and their agents.*

Signature_____ Date _____

If patient is under the age of 18, authorised parent/carer may give consent, please state:

Print Full Name: _____ Relationship to patient:_____

**Patients may withdraw their consent to share information at any time, by advising of such in writing.*

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Medication List

Please make sure that