**DANDENONG NEUROLOGY**
**1 BRUCE STREET**
**DANDENONG 3175**

Dandenong Neurology

# PATIENT INFORMATION FORM

**SURNAME** **GIVEN NAMES** **MR/MRS/MS/MISS**

**ADDRESS**

**POSTCODE**

**TELEPHONE (HOME)** **(WORK)** **(MOBILE)**

**DATE OF BIRTH** **AGE** **OCCUPATION**

**NAME & ADDRESS OF REFERRING DOCTOR**

**NAME & ADDRESS OF FAMILY DOCTOR**

**MEDICARE - NO** **PATIENT NO** **EXPIRY DATE**

**PENSION/HEALTH CARE CARD/VETERANS CARD NUMBER:**

**WORKCOVER/TAC:**

**INSURANCE COMPANY:** **DATE OF INJURY:**

**CLAIM NO:**

**LIST CURRENT MEDICATIONS(if not listed on referral)**

**DO YOU HAVE ANY ALLERGIES ?** **YES/NO**

**IF YES-PLEASE INDICATE HERE:**

**You require a valid referral to qualify for full Medicare rebate of fees charged. Please ensure your referral is current. If you are not sure about your referral please ask the staff.**

**PLEASE KEEP US INFORMED REGARDING ANY CHANGE IN YOUR CIRCUMSTANCES**

**Please read our privacy statement located in the waiting room titled "your privacy is our business" if you require information on how to access your medical file.**

**I hereby authorise Dandenong Neurology to obtain details of my previous illness.**

**Signed.....**

**Today's Date** _____