Mr David Oehme
NEUROSURGEON & SPINE SURGEON
MBBS(Hons) PhD FRACS
Minimally Invasive Specialist

MAIN ROOMS
St Vincent's Hospital, Suite B, Level 2, Healy Wing
41 Victoria Parade Fitzroy Victoria 3065
Phone 1800 367 746 (1800 DO SPINE) / (03) 9021 8855
Fax (03) 9005 2811 Email contact@doneurosurgery.com

NEW PATIENT TELEHEALTH REGISTRATION FORM

SURNAME: **GIVEN NAME:**

DATE OF BIRTH:

ADDRESS: **POSTCODE:**

E-MAIL:

TELEPHONE: (H) **(MOB)**

OCCUPATION:

NEXT OF KIN: (PLEASE SUPPLY EMERGENCY CONTACT)

1. NAME RELATIONSHIP

CONTACT NO'S (H) MOBILE

DO YOU HAVE PRIVATE HEALTH INSURANCE? YES NO

NAME OF FUND **MEMBERSHIP NO**

DO YOU HAVE HOSPITAL COVER? YES NO

DOES YOUR PRIVATE HEALTH INSURANCE COVER SPINAL SURGERY IN A PRIVATE HOSPITAL? YES NO

MEDICARE NUMBER: REFERENCE NUMBER:

DO YOU HAVE AN AGED PENSION CARD? YES NO

CARD NO **EXPIRY DATE**

ARE YOU COVERED BY VETERAN'S AFFAIRS? YES NO **CARD NO**

IS YOUR ILLNESS, CURRENTLY OR PREVIOUSLY, THE SUBJECT OF A WORKCOVER OR TAC CLAIM? YES NO

ARE YOU PLANNING ON LODGING A CLAIM WITH WORKCOVER OR TAC IN THE FUTURE? YES NO

ARE YOU SEEKING A MEDICAL REPORT, MEDICO-LEGAL OPINION, INSURANCE CLAIM OR SIMILAR REPORT FOLLOWING YOUR CONSULTATION? YES NO

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GENERAL PRACTITIONER DETAILS

NAME PH:

ADDRESS: POST CODE:

MEDICATIONS:

DO YOU TAKE BLOOD THINNING MEDICATION?:

ASPIRIN ☐ PLAVIX ☐ CLOPIDOGREL ☐ ASASANTIN ☐ WARFARIN ☐ PRADAXA ☐ XERALTO ☐

SMOKER: YES ☐ NO ☐ * **DIABETES:** YES ☐ NO ☐

HAVE YOU PREVIOUSLY UNDERGONE SPINAL SURGERY? YES ☐ NO ☐

IF YES: **WHEN** **WHERE**

SYMPTOMS:

DO YOU HAVE BACK PAIN?	YES ☐ NO ☐
DO YOU HAVE NECK PAIN?	YES ☐ NO ☐
DO YOU HAVE ARM PAIN OR NUMBNESS?	YES ☐ NO ☐
DO YOU HAVE ARM OR HAND WEAKNESS?	YES ☐ NO ☐
DO YOU HAVE LEG PAIN OF NUMBNESS?	YES ☐ NO ☐
DO YOU LEG OR FOOT WEAKNESS?	YES ☐ NO ☐

I AM RESPONSIBLE FOR ALL MY ACCOUNTS. I UNDERSTAND THAT IN THE EVENT WHERE MY OVERDUE ACCOUNT IS REFERRED TO A COLLECTION AGENCY AND/OR LAW FIRM, I WILL BE LIABLE FOR ALL COSTS WHICH WOULD BE INCURRED AS IF THE DEBT IS COLLECTED IN FULL, INCLUDING LEGAL DEMAND COSTS. I AGREE FOR THE CLINIC TO HANDLE MY PERSONAL INFORMATION ACCORDING TO THE HPPS AS SET OUT BY THE HEALTH RECORDS ACT (VIC) 2001 AND THE PRIVACY AMENDMENT (ENHANCING PRIVATE PROTECTION) ACT 2012 (CTH) .(FOR ANY QUERIES PLEASE FEEL FREE TO DISCUSS WITH THE CLINIC STAFF.)

SIGNATURE **DATE**

Please email completed form to telehealth@doneurosurgery.com