Neurosurgery55
Brain and Spine Specialists

Mr Tiew Han, MBBS FRACS
Consultant neurosurgeon
Ph: 9417 3138
Fax: 9417 3139
email: neurosurgery55@live.com.au

Personal Details

Mr Mrs Master Miss Ms Dr Prof Other Date of Birth: _____/_____/_____

Surname: _____ Given Name: _____

Address: _____

Suburb: _____ Postcode:_____

Email: _____

Occupation: _____

Telephone Numbers: Home: _____

Work: _____ Mobile:_____ Emergency: _____

Next of kin details (family member or friend / medical power of attorney)

Name: _____ Relationship to you:_____

Contact number: _____

Do you consent for Mr Han or his staff to leave a message on your Home/Mobile Number? YES / NO

Do you consent for Mr Han or his staff to leave a message with your Emergency Contact Person? YES / NO

GP's Details

Name: _____ GP Provider Number: _____

Practice address:_____

Contact number: _____

Medicare and Private Health Insurance Details

Medicare Number: _____ Ref No: _____ Exp Date: _____

Private Health Insurance: Yes No

Fund Name: _____ Fund Number: _____

Level of cover: _____

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Concession Cards:

Aged or Disability Pension No: _____ Exp Date: _____

Dept. Veterans Affairs Card No: _____ White Gold Exp Date: _____

Health Care Card No: _____ Exp Date: _____

WorkCover Details (If applicable)

Is this visit related to a WorkCover injury Yes No

W/C Claim No: _____ Date of Injury: _____

Insurer: _____ Employer: _____

Claims Officer Details

Name:_____ Phone:_____ Fax: _____

TAC Details (If applicable):

Date of Accident: _____ Claim Number: _____

Claims Officer Details

Name:_____ Phone:_____ Fax: _____

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Medical History

Please list current medications:

_____

_____

Please list previous surgical procedures:

Operation: _____ Year Performed: _____

Operation: _____ Year Performed: _____

Operation: _____ Year Performed: _____

Do you smoke cigarettes? Yes / No If so, how many and for how long? _____

Do you take any blood thinning agents (eg Warfarin, Plavix, Aspirin, Asasantin etc)? Yes / No

Details: _____

Do you have any allergies? Yes / No If yes please include details:

_____

_____

Please indicate if you suffer or have suffered from any of the following:

Deep venous thrombosis (DVT)	Yes ☐ No ☐	Coronary Stent	Yes ☐ No ☐
Heart Attack	Yes ☐ No ☐	Migraines	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐	Tuberculosis/chronic infection	Yes ☐ No ☐
Pulmonary embolism (PE)	Yes ☐ No ☐	Angina	Yes ☐ No ☐
Open Heart Surgery	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Asthma / COAD	Yes ☐ No ☐
Bleeding disorder	Yes ☐ No ☐		

Other:

_____

_____

_____

_____

_____

_____

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Privacy

All information collected by this practice will be used for providing healthcare. Collection and utilization and storage of this information will be compliant with the 2001 Health Records Act.

I consent to Mr Tiew Han collecting and storing my health information:

Signature: _____ Date: ___/___/_____

Name: (Please Print) _____

Payment Policy

In the event that an invoice remains unpaid we will engage a debt collector to collect the debt and add any commission charged to your overall debt.

SIGNED_____

How did you hear about us?

Referred by Doctor:

GP or Specialist _____

or (Please circle)

Our Website

Royal Australian College of Surgeons (RACS) website

Google Search

Yellow Pages

White Pages

Personal recommendation: (details)_____

Other: (details) _____