A/Prof Lynette Kiers – Neurologist

Patient Registration Form

Is this your first visit to Dr Kiers? **YES** □ **NO** □
Is this your first EMG/NCS? **YES** □ **NO** □

WHICH DOCTOR ARE YOU SEEING TODAY? _____

TITLE: _____ **SURNAME**: _____

GIVEN NAME: _____**MIDDLE NAME/S**: _____

POSTAL ADDRESS: _____

SUBURB: _____ **POSTCODE**: _____

PHONE: (H)_____ (W)_____ (M)_____

EMAIL: _____

DATE OF BIRTH: _____/_____/_____

EMERGENCY CONTACT/NEXT OF KIN: Name: _____

Relationship: _____ Phone: _____

REFERRING DOCTOR: _____ Phone: _____

GP: _____ Phone: _____

Address: _____ Fax: _____

EXTRA COPIES OF THE EMG REPORT TO: Name, Clinic and Address (e.g. General Practitioner, Specialist):

_____

_____

MEDICARE NUMBER: _____ Ref no: _____ Expiry Date: ____/____/_____

PENSION NUMBER: _____Expiry Date: ____/____/_____

VETERANS AFFAIR NUMBER: _____Gold/White Expiry Date: ____/____/_____

WORKCOVER/TAC CLAIM NUMBER _____Date of Injury: ____/____/_____

Name and Address of Insurance Company: _____

Name of Case Manager: _____ Phone: _____ Fax: _____

Name of Employer: _____ Phone: _____

Address of Employer: _____

I give my consent for the above named doctor to use my information to communicate with other medical professionals.

Signed: _____**Date:** ____/____/_____