Information in preparation for your appointment

MACQUARIE PLASTIC SURGERY.

Your personal details

Full name			Date of birth
Title (Mr/Mrs/Ms/Dr etc)	Preferred name		Male ☐ Female ☐
Address			
Suburb		State	Postcode
Occupation		Employer	
Email address			
Telephone	Home	Work	Mobile
Which of the above is your preferred phone number to contact regarding results, recalls or an appointment?			
Emergency contact name			Relationship
Emergency contact number			
We can send an SMS message to your mobile phone to confirm your appointment or advise of a change. If you **DO NOT** wish for us to extend this service to you, please tick this box ☐			

Health care details

Referring doctor		Name of usual GP	
GP address			
Medicare number		Reference number	Expiry
DVA Gold Card number (if applicable)			Expiry
Pension or Concession Card		**Yes** ☐ **No** ☐	
If yes, please note type – e.g. Health Care Card, Age Pension, Seniors Health etc			Type
	Reference number		Expiry
Private Health Insurance	**Yes** ☐ **No** ☐		
If yes, please select	Extras only ☐	Hospital only ☐	Extras + Hospital ☐
Name of Private Health Provider		Membership number	
Is this consultation covered by MAIB or Worker's Compensation? **Yes** ☐ **No** ☐ If yes, see below			
MAIB or name of insurer			
Date of accident		Claim number	

Personal medical history

In relation to your consultation	
Have you had any recent pathology tests? **Yes** ☐ **No** ☐	
Have you had any recent radiology tests? (e.g. x-rays, scans, ultrasounds) **Yes** ☐ **No** ☐	
Have you ever suffered from the following?	
Major heart or lung disease	**Yes** ☐ **No** ☐
Asthma	**Yes** ☐ **No** ☐
Hepatitis	**Yes** ☐ **No** ☐
Blood Clots in Legs	**Yes** ☐ **No** ☐
Epilepsy	**Yes** ☐ **No** ☐
Diabetes	**Yes** ☐ **No** ☐
Do you have a history of a multi-resistant organism (MRSA / Clostridium difficile / VRE / other)?	**Yes** ☐ **No** ☐
If yes, please provide details	
Any other medical condition? If yes, please provide details	**Yes** ☐ **No** ☐

Are you on any medication at the present time? (Including any Aspirin or Warfarin)			**Yes** ☐ **No** ☐
If yes, please provide details			

Do you have any allergies to drugs, including anaesthetic, antibiotics, dressings, tape, other?
If yes, please provide details

Patient consent to collect information

To ensure quality and continuity of patient care, a patient's health information may need to be shared with other health care providers/diagnostic facilities. Some information about patients is also provided to Medicare and private health funds, if relevant, for billing and medical rebate purposes.

I consent to images (still photographs or video) being taken for record keeping, therapeutic monitoring and education purposes.

I _____ understand and consent to the above.

Your signature _____ Date _____