Patient Information and Consent

Patient Information

☐Mrs ☐Ms ☐Miss ☐Mr ☐Mstr ☐Dr ☐Prof ☐Other_____

Surname: _____ First Name: _____

Preferred Name:_____

Address: _____ Suburb: _____ Postcode: _____

Contact Number/s: Home: _____ Mobile: _____ Work: _____

Date of Birth: ___/___/_____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐De facto

Do you smoke? ☐No ☐Yes How many per day? _____ ☐Ex-smoker When did you quit? _____

Have you ever had: ☐Diabetes ☐High blood pressure ☐Asthma ☐Heart disease ☐Kidney Disease ☐Stroke
☐ Any other medical conditions. Please list:

Have you had any previous operations? Please list:

Do you take any blood thinners?

☐None
☐Warfarin (Marevan/Coumadin)
☐Aspirin Prescribed by GP/Specialist ☐ Self Prescribed ☐
☐Clopidogrel (Plavix)
☐Fish Oil
☐Apixaban (Eliquis)
☐Dabigatran (Pradaxa)
☐Rivaroxaban (Xarelto)
☐Other: _____

Please list any other medications you take regularly:

Do you have any allergies? ☐No ☐Yes Please list:

Regular GP (if not your referrer) : _____ **Phone:** _____

Medicare Card Number ☐☐☐☐☐☐☐☐☐☐ Ref ☐ Expiry date: _____/_____
HCC/Pension Card Number: _____ Expiry date: ___/___/____
DVA Number: _____ Expiry date: ___/___/_____ Colour: _____
Health Fund: _____ Membership Number: _____

Do you consent to our practice contacting you via SMS? ☐Yes ☐No Best number: _____
Do you consent to our practice contacting you via email? ☐Yes ☐No
Best email to contact you: _____

Emergency contact
Full name: _____ Relationship: _____
Contact Number(s): Home: _____ Mobile: _____ Work: _____

How did you find out about us? ☐Dr Referral ☐Internet ☐Social Media ☐Word of mouth ☐Other

I give my consent for my personal and medical information to be used for the following purposes:

- Follow up reminder/recall notices for treatment and preventative healthcare
- For accounting procedures and the collection of professional fees
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- For legal related disclosure as required by a court of law
- To allow medical students and staff to participate in medical training/teaching using only unidentified information
- For disease notifications required by law

I also give my consent for my personal and medical information:

- To be shared with other health providers involved in my care
- To access medical information from other health providers involved in my care

I understand that only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying the practice in writing.

Photography Consent

I agree that images may be : Placed in my medical record for future reference
That unidentified images may be used by health professionals for education and training
That unidentified images may be used in paper or electronic health publications

I agree that unidentified data (anonymous details) can be used by my doctor for research,
I understand that no data identifying me will be used.

☐Agree ☐Disagree

Audio Recording Consent

I agree that and audio recording of ALL my consultations with Dr Kirstin Miteff and the ASPIRE Plastic Surgery team will be kept and will form part of my confidential medical file. I acknowledge that the audio recording, or copies of it, will not be shared or provided to anyone without the consent of all parties to the consultation, unless required by law.

☐Agree ☐Disagree

Signed: _____ Date: ___/___/_____