

PATIENT DETAILS

Surname..... (Mr / Mrs / Miss / Ms / Dr)

Given Names (As listed on your Medicare card)

Date of Birth Country of Birth

Address Suburb.....Postcode.....

Tel: Home Work Mobile

Email address: Consent to email correspondence

Preferred Language (Please circle): English / Other

NEXT OF KIN:..... Relationship: Tel:.....

REFERRAL DETAILS

Please leave this section blank if it is the same as your referral letter.

Local / Family GP Tel:

Address Suburb..... Postcode.....

How did you hear about Eastern Plastic Surgery?

- GP referral Emergency Social Media
- EPS Website Other Website
- Personal Recommendation Other

ACCOUNT DETAILS

Medicare Number _____ Ref No _____ Exp Date

DVA Gold or White / Pension (Please circle) Card Number

Private Health Fund Name: Membership No.....

Please note: If you are a member of NIB, please expect to pay surgical fees in full upfront due to the restrictions imposed by your health fund.

WORKCOVER *If a Workcover/TAC account is not settled within 30 days it becomes the responsibility of the patient.*

Employer: Company: Tel:

Address Suburb..... Postcode

Workcover Insurer Claim Number.....

Date of Injury Injured Area.....

TAC - Claim No Date of Accident

Consultation Fees:	Initial Consult	Subsequent Consult
Mr Frank Lin	\$200.00 (Medicare Rebate \$78.05)	\$100.00 (Medicare Rebate \$39.25)
Dr Neela Janakiramanan	\$220.00 (Medicare Rebate \$78.05)	\$100.00 (Medicare Rebate \$39.25)
Mr Paul Di Giovine	\$200.00 (Medicare Rebate \$78.05)	\$100.00 (Medicare Rebate \$39.25)
Dr Tam Quinn	\$200.00 (Medicare Rebate \$78.05)	\$100.00 (Medicare Rebate \$39.25)

Aged Pension & Disability card holder rates available.

All fees must be settled at the time of presentation of the account.

PLEASE TURN OVER & COMPLETE PAGE 2

GENERAL HEALTH QUESTIONNAIRE

Do you have or suffer from any of the following medical problems? (Please tick the correct answer)

MEDICAL CONDITION	YES	NO	MEDICAL CONDITION	YES	NO
Heart Conditions:	<input type="checkbox"/>	<input type="checkbox"/>	<u>Diabetes</u>	<input type="checkbox"/>	<input type="checkbox"/>
Stents / Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	If 'YES' to Diabetes, is it controlled with:		
Pacemaker/Implantable Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Diet Only <input type="checkbox"/> Tablets <input type="checkbox"/> Insulin Injection <input type="checkbox"/>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<u>DVT / PE</u> (Clots in your legs or lungs)	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	If 'YES' to DVT/PE: Date of last event?		

Allergies YES NO **Latex Allergy** YES NO

If 'YES' to Allergies, please list type and reaction:

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Do you take any blood thinning medication(s)? YES (Please tick all that apply) NO

Aspirin / Cartia Clopidogrel / Plavix Warfarin Apixaban/Eliquis Other

Are you a current smoker? YES, how many cigarettes do you smoke a day?

NO Ex-smoker, when did you quit smoking?

Do you drink alcohol? YES, how often? NO

Please list all your regular medications, including oral contraceptive pill, herbal supplements (if any)

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CLINICAL PHOTOGRAPHY

Clinical photographs and are a valuable resource in providing a high level of health care. Eastern Plastic Surgery routinely uses clinical photos for record keeping, tracking your progress/recovery, and for educating other patients and health care professionals. Your photo constitutes part of your confidential medical records and is stored securely in accordance with Federal and State Legislations. Other than for record keeping, your photos will be de-identified and your name and personal details will never be used.

If you do not consent to clinical photographs to be part of your treatment please inform the Practice Manager.

PRIVACY STATEMENT

In order to comply with Federal and State Privacy Legislations, we require your consent to collect personal information about you. Information collected is used for the main purpose of providing quality health care and may be used for administrative and billing purposes. It may be disclosed to others involved in your health care, including, but not limited to, other treating doctors, hospitals, health care related services, medical diagnostic services and your GP/referring doctors.

I have read the above information and give consent to the collection of my personal information by Eastern Plastic Surgery.

Signature of patient Date.....

Print name of patient If other, relationship with patient