BRIGHTON PLASTIC SURGERY

Confidential Patient Registration Form

We ask that you complete all information to assist us in providing you with the best possible care.

Mr / Mrs / Ms / Miss
Surname: **Given Names:**

Address:

Person responsible for the account:

Date of Birth: Age: Occupation:

Telephone: Home: **Mobile:**
Email address:
Would you like to receive our "Surgery News" via email? **Yes/No**
Are we able to SMS for appointment confirmation? **Yes / No**

Health Insurance Fund: **(Hospital Cover only)**
Membership No: **Date Joined:**

Veterans Affairs No:

Medicare No: Ten digits:

Expiry Date: ...../20.....

Card Ref No. (Number next to your name):

Name of your local doctor: **Telephone:**

Aboriginal or Torres Strait Islander: Yes / No

Country of Birth:

Next of Kin: **Contact Telephone Number:**

Our practice specialises in the following procedures.

Please indicate if you would like to discuss any of the following with Mr Mutimer during your consultation.

□ Facial Rejuvenation/Facelift
□ Endobrowlift
□ Upper/Lower Blepharoplasty (Eyelids)
□ Rhinoplasty (Nose)
□ Chin or Cheek Implant
□ Fat Injections
□ Breast Augmentation
□ Otoplasty
□ Armlift
□ Breast Reduction
□ Necklift
□ Thighlift
□ Breast Mastopexy (Uplift)
□ Liposuction
□ Abdominoplasty (Tummy Tuck)
□ Gynaecomastia (Male Breast Surgery)

Please turn over……

General Health History

Do you have any of the following medical conditions? **(Please tick if yes)**

□Heart Disease	□Arrhythmias/Palpitations	□Kidney Disease	□Mental Illness
□Heart Attack	□Cardiac Stents	□Joint Replacements	□Cold Sores
□Angina	□High Blood Pressure	□HIV/AIDS Exposure	□Hepatitis
□Stroke	□Diabetes	□Pacemaker	□Sleep Apnoea
□Valve Replacements			

If other, please state:

Are you taking any medications or drugs? **(Please tick if yes)**

□Warfarin	□Sedatives	□Complementary Therapies
□Cortisone	□Pain Killers	□Vitamins
□Aspirin	□Oral Contraceptives	□Anti-Depressants
□Any other 'blood thinner'	□Blood Pressure Tablets	□Anti-Inflammatories

If other, please state:

Are you allergic to any medicines, tapes or latex? **Yes / No**
If yes, please state:

Have you had any operations in the past (including cosmetic surgery)? **Yes / No**
Please list including dates and indicate any complications:

Have you or your family had any problems with anaesthetics in the past? **Yes / No**

Do you or any family members have a history of bleeding problems? **Yes / No**
Please state details:

Do you see any Specialists? (e.g. Cardiologist) **Yes / No**
If yes, name of Specialist(s) and telephone number(s):

Do you regularly drink alcohol? If yes, how much alcohol do you consume per day/week? .....

Do you smoke? If yes, how many per day? .....
Are you a reformed smoker? If yes, when did you give up? .....

Females: Are you or could you be pregnant? **Yes/No** If yes, how many weeks? .....

How did you hear about Mr Mutimer?

WEIGHT: ..... kg HEIGHT: ..... cm

Signed **Date:**

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