Plastic & Reconstructive Surgery Melbourne

PATIENT REGISTRATION FORM

Title: First Name: Surname:

DOB: Address:

Home Phone: Mobile:

Occupation: Email Address:

Next of Kin: Relationship: Number:

General Practitioner:

Medicare: Ref No:

Private Health Fund: Membership No:

Concession/Pensioner: YES ☐ NO ☐ _____

TAC/Workcover: YES ☐ NO ☐ _____

DVA: YES ☐ NO ☐ _____

Blood Thinners: Diabetic: Type 1 ☐ Type 2 ☐

Pacemaker or Stent: Drug allergies:

Other Medications:

PRIVACY POLICY

To comply with the Privacy Laws **(Privacy Act Amendments – Private Sector – Act 2004)** your agreement to the following statement is required: I agree to allow the Doctors of Plastic & Reconstructive Surgery Melbourne access to all relevant information regarding my medical conditions. I understand that PRSM may be required to forward information about my medical condition or history to other health care providers.

PAYMENT POLICY

For all consultations and any treatment provided in our private rooms, the fee is payable on the day of service. For all cosmetic patients, any surgical procedure booked in hospital requires full payment 10 days prior or the surgery will be cancelled.

PHOTOGRAPHY POLICY

All patients that have treatment and surgery with Plastic & Reconstructive Surgery Melbourne have before, during and after photos taken. This is an important part of a patient's medical care and will be kept in your confidential medical record. I agree that the images can be used for the following purposes:

YES ☐ **NO** ☐ Placed in my medical record & shared with treating medical practitioners as required.

SIGNATURE: _____ **DATE:** _____