caps Clinic

CANBERRA AESTHETIC
PLASTIC SURGERY

patient information form

TITLE: .... FIRST NAMES: .... SURNAME: ....

ADDRESS: ....

SUBURB: .... STATE: .... POSTCODE: ....

DATE OF BIRTH: .... ETHNIC BACKGROUND: ....

MARITAL STATUS: .... OCCUPATION: ....

WORK PHONE: .... HOME PHONE: ....

MOBILE: .... EMAIL: ....

NEXT OF KIN: .... NEXT OF KIN PHONE: ....

PARENTS NAMES (IF PATIENT IS UNDER 18 YEARS): ....

HOW DID YOU HEAR ABOUT THE CAPS CLINIC? ....

MEDICARE NUMBER: .... CARD REF NO: .... EXP: ....

PRIVATE HEALTH FUND: .... MEMBERSHIP NO: ....

DVA NUMBER: .... CARD COLOUR: WHITE / GOLD

HCC/PENSION NUMBER: .... EXP: ....

FAMILY DOCTOR: .... SUBURB: .... PHONE: ....

REFERRING DOCTOR: .... SUBURB: .... PHONE: ....

KNOWN ALLERGIES: ....

DO YOU TAKE ANY *ANTI-INFLAMMATORY* OR *BLOOD THINNING* MEDICATION (E.G. ASPIRIN)? (PLEASE CIRCLE)

CURRENT MEDICATIONS / VITAMINS / MINERALS: ....

....

SURGICAL / MEDICAL HISTORY: ....

....

IF THIS CONSULTATION IS FOR INSURANCE OR WORKER'S COMPENSATION CLAIM PLEASE INFORM THE RECEPTION STAFF

PRIVACY STATEMENT: IT IS THE POLICY OF THE CAPS CLINIC THAT OUR PATIENT'S PERSONAL HEALTH INFORMATION WILL ONLY BE USED OR DISCLOSED IN THE PROVISION OF A PATIENT'S CARE. THE CLINIC HAS ESTABLISHED A PRIVACY POLICY IN COMPLIANCE WITH THE NATIONAL PRIVACY ACT OF 2001. COPIES OF THIS POLICY ARE AVAILABLE ON REQUEST.