Dr Frederick Clarke
BSc (Hons) MBBS MS FRACS (Plastic Surgery)
Plastic, Reconstructive and Cosmetic Surgeon
Provider No: 250080TK

Patient Registration

Name_____ _____ _____/_____/_____ _____
Title Given Name(s) Surname Date of Birth Age

Address_____Suburb_____ P/code_____

Home_____ Mobile_____ Work_____

Email_____

Referring Doctor_____ Name of GP if different_____

Medicare No_____ Your position on card_____ Expiry_____/_____

Private Health Fund_____ Membership No_____ Min. 12mths? Yes / No

Occupation_____ Employer_____

Next of Kin_____Relationship_____

Telephone_____

HOW DID YOU FIRST FIND OUT ABOUT US? (Please Tick)

☐ Family / Friend_____

☐ Internet search ☐ Private health insurer Surgeon list ☐ ASPS ☐ GP ☐ Specialist

☐ Other_____

HEALTH QUESTIONNAIRE

Height (cms)_____ Weight (kgs) _____ Daily Intake Smoking_____ Daily Intake Alcohol _____

Any significant medical problems? _____

Past operations (include cosmetic surgery) _____

ALLERGIES? _____ Dressings/tapes? _____

Regular Medications (include aspirin & herbal preparations) _____

Do you have a **HISTORY** of the following? (Please Tick)

☐ Asthma	☐ Rheumatic Fever	☐ Contact Lenses	☐ Cold Sores
☐ Diabetes	☐ Blood Clots	☐ Psychiatric Treatment	☐ Healing Problems
☐ High Blood Pressure	☐ Arthritis	☐ Hepatitis	☐ Keloid Scars
☐ Heart Conditions	☐ Spinal/Neck Problems	☐ HIV/AIDS Exposure	☐ Wound Infections
☐ Use steroids/cortisone	☐ Anaesthetic problems	☐ Bleeding disorders	

Note: If your personal details or medical condition ever changes in future, please ensure you advise us.

CONSENT

I give permission for clinical photographs to be taken as part of my consultation	YES	NO
My clinical photographs may be used for medical education purposes (doctors/nurses/medical students only)	YES	NO
My clinical photographs may be used for public education purposes	YES	NO
My consultation notes may be used in communication with other health professionals involved in my care	YES	NO

Patient / Guardian Signature_____ **Date**_____