Dean White MBBS FRACS
Plastic & Reconstructive Surgeon

Skin Cancer, Reconstructive & Cosmetic Surgery

CONFIDENTIAL PATIENT INFORMATION

NEW PATIENT FORM

PERSONAL DETAILS

☐ Mr ☐ Mrs ☐ Master ☐ Miss ☐ Ms ☐ Dr ☐ Prof ☐ Other

Surname:_____ **Given Name:** _____

Date of Birth: _____/_____/_____

Address: _____

Phone: Home: _____ Work:_____ Mobile: _____

CLAIM DETAILS:

Medicare Number: _____ Ref No: _____ Exp Date: _____

Private Health Insurance: ☐ Yes ☐ No Fund Name: _____ Fund Number: _____

CONCESSION CARD:

Aged or Disability Pension No:_____ Exp Date: _____

Dept. Veterans Affairs Card No: __ _____ ☐ White ☐ Gold Exp Date: _____

Health Care Card No: _____ Exp Date: _____

WorkCover (If applicable) Claim No: _____ Insurer: _____

TAC Details (If applicable): Date of Accident: _____ Claim Number: _____

REFERRAL SOURCE: Doctor - ☐ GP or ☐ Specialist

How did you hear about Mr White?

☐ Website – www.deanwhite.com.au ☐ Google ☐ Referred by Doctor

☐ or via a link from another website eg Australian Society of Plastic Surgeons (ASPS) Website

☐ Yellow Pages ☐ Personal recommendation: _____

☐ Other: _____

Privacy

Are you happy for communication to be sent to your family doctor? ☐ Yes ☐ No

Details if different from referring doctor: _____

Are you happy for Mr White to call your next of kin after any operations? ☐ Yes ☐ No

Next of kin details

Name: _____Relationship to you:_____

Contact number: _____

PLEASE TURN OVER

Suite 19, Level 3
Epworth Eastern Medical Centre
1 Arnold Street Box Hill VIC 3128

Tel: (03) 9895 7631 **Fax:** (03) 9895 7646
Paging Service: 9387 1000

Email: info@deanwhite.com.au
Web: www.deanwhite.com.au

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MEDICAL QUESTIONNAIRE

MEDICAL HISTORY

CARDIAC: Have you ever suffered from any of the following? ☐ **Heart Attack** ☐ **Chest Pain** ☐ **Angina** (Please tick if relevant)

Do you have a Pacemaker? ☐ Yes ☐ No **Have you had an: Angiogram** ☐ Yes ☐ No **Stents** ☐ Yes ☐ No **Bypass Surgery** ☐ Yes ☐ No

Have you ever suffered from: Stroke ☐ Yes ☐ No **TIA (ministroke)** ☐ Yes ☐ No

DIABETES: Do you suffer from Diabetes? ☐ Yes ☐ No If Yes, is your Diabetes controlled by: ☐ **Diet** ☐ **Tablets** ☐ **Insulin Injections**

ASTHMA: Do you suffer from Asthma? ☐ Yes ☐ No If Yes, how is your Asthma managed?

_____

EPILEPSY: Do you suffer from Epilepsy or have ever experienced seizures? ☐ Yes ☐ No

DVT/PE: Have you ever suffered from a DVT or Pulmonary Embolism (clots in your legs or your lungs)? ☐ Yes ☐ No

SMOKING: Are you currently a smoker? ☐ Yes ☐ No If Yes, how many per day? ___ If an Ex Smoker, Date stopped _____ Number ___

MEDICATIONS:

Do you take any ***Blood Thinning Medications*** such as: ☐ Aspirin ☐ Warfarin or ☐ Plavix/Clopidogeral (Please tick if relevant)

Please list all Medications including herbal or vitamin preparations: _____

_____

If Female: Do you use the Oral Contraceptive Pill? ☐ Yes ☐ No or Have a Contraceptive Implant? ☐ Yes ☐ No

ALLERGIES:

Do you have any known **Allergies?** ☐ Yes ☐ No If Yes, Please list or describe: _____

_____

What is your: **Approximate Height:** _____ **Approximate Weight:** _____

PHOTOGRAPHY CONSENT

For nearly all patients clinical photographs will be taken to assist in your care. These become a part of your confidential medical records. We also would like to ask you for permission to use these photos for educational purposes in addition to their use as part of your medical care. All images used for purposes other than the medical records are de-identified. Names are not used and as far as possible identifying factors are masked.

Do you consent to these images being used for the purpose of teaching other health professionals such as doctors, nurses and associated students?

☐ Yes ☐ No

Do you consent to these images being used for publication as articles in medical journals?

☐ Yes ☐ No

Do you consent to these images being used to educate other patients?

☐ Yes ☐ No

Signature: _____ **Date:** _____/_____/_____

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