

**NEW PATIENT DETAILS**

Surname \_\_\_\_\_ Title: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Parents' Name (if under 18 years old): \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Next of Kin Contact Number \_\_\_\_\_

**REFERRING DOCTOR:**

Name: \_\_\_\_\_

Date of Referral: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**GENERAL PRACTITIONER (if not as above)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**HEALTH INSURANCE DETAILS:**

Medicare No: \_\_\_\_\_ Expiry: \_\_\_\_\_

Position: \_\_\_\_\_ Private Health Fund Name: \_\_\_\_\_ Fund No: \_\_\_\_\_

Position: \_\_\_\_\_ Veterans Affairs: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT DR YUNAEV OR BREAST & BODY CLINIC? (Tick one or more)**

- |  |  |
|--|--|
| <input type="checkbox"/> GP              | <input type="checkbox"/> Instagram     |
| <input type="checkbox"/> Specialist      | <input type="checkbox"/> TV            |
| <input type="checkbox"/> Internet Search | <input type="checkbox"/> Magazine      |
| <input type="checkbox"/> Facebook        | <input type="checkbox"/> Word of Mouth |

Referred by a friend (Name?) \_\_\_\_\_

Have you visited our website [www.bbclinic.com.au](http://www.bbclinic.com.au)? Y  N

Have you liked our Facebook page? Y  N  Instagram? Y  N

**PLEASE ADVISE US IF YOU ARE MAKING A CLAIM FOR COMPENSATION FEES**

**This is a private practice and we do not bulk bill.**

The fees charged by this practice are generally higher than those recommended by the Australian Medical Association and are payable at the time of consultation.

**Initial Consultation \$290.00**

**Subsequent Consultation \$145.00**

The following payment methods are available: Cash, Cheque, EFTPOS (Visa, MasterCard, AMEX and Debit only)

Please note, if paying with Credit Card, surcharge of 1.5% for AMEX, VISA and Master Card will apply.

If you are paying in cash, please note that we do not keep cash on the premises, the exact payment is appreciated.

**GENERAL COMPLAINT PATIENT QUESTIONNAIRE:**

**Describe your Current Problem/Issue:**

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**Other Symptoms present (please specify):**

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**Recent Investigations (date, where, results):**

**X-ray/Ultrasound:**

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**CT Scan:**

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**MRI:**

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**Biopsy:**

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**Other:**

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**Previous Medical History (tick where appropriate):**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Pacemaker/Defibrillator     | <input type="checkbox"/> Sleep Apnoea                                 |
| <input type="checkbox"/> Raised Cholesterol           | <input type="checkbox"/> Prosthetic devices/Implants | <input type="checkbox"/> Kidney Problems                              |
| <input type="checkbox"/> Heart Attack/Stent insertion | <input type="checkbox"/> Epilepsy/Seizures           | <input type="checkbox"/> Liver Problems                               |
| <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Anxiety/Depression          | <input type="checkbox"/> Deep vein thromboses                         |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Bipolar Disorder/Psychosis  | <input type="checkbox"/> Problems with anaesthetic<br>eg. vomiting    |
| <input type="checkbox"/> Emphysema                    | <input type="checkbox"/> Drug Use (IV and other)     | <input type="checkbox"/> Problems with keloid or thick/<br>ugly scars |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Cancer history              |   |

If you ticked yes above please provide further information:

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Other conditions not listed above:

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Previous Surgical History (list procedures and dates):

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Do you use blood-thinning medications? What are they?

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List your other medications:

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Do you have any Allergies?

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**Smoking habits:**

- smoker
- ex-smoker
- never smoked

**SOCIAL ENVIRONMENT:**

What is your current or previous occupation? \_\_\_\_\_

Who do you live with? / Who is at home with you? \_\_\_\_\_

Do you have children? What are their ages? \_\_\_\_\_

Do you require assistance with daily activities? \_\_\_\_\_

**Do you require a chaperone (an accompanying person in the room) to be present during your clinical examination? Yes \_\_\_\_\_ No \_\_\_\_\_**

## CONSENT

### SOCIAL MEDIA / PHOTOGRAPHY

I consent to the use of my de-identified pre and post surgery images to be used for medical education, consultation and/or promotion on the following digital platforms (please cross out any points that you DO NOT consent to):

- Medical Journal publications, Medical presentations
- Email
- Facebook
- Instagram
- Snapchat

## PRIVACY NOTE

I agree to allow for the doctors and staff at this practice to access all relevant information regarding my medical conditions. I agree that the doctors and staff may be required to forward/obtain information about my medical history/condition from the referring doctor and/or other health professionals. I understand my clinical records may be accessed or reviewed by staff at this practice.

**I hereby certify that the medical information I have provided above is true and accurate to the best of my ability.**

**I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery Fees and I will also be responsible for any legal costs incurred.**

**I declare that, to the best of my knowledge, the information I have provided in the form is accurate:**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If under 18 years old, please sign by parent:**

**Name:** \_\_\_\_\_ **Best Contact number:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Our Clinic offers Anti-Aging Cosmetic Injection service, is this of interest to you? Yes \_\_\_\_\_ No \_\_\_\_\_**

**If Yes, would you like to book in for a Free Consultation to discuss this further? Yes \_\_\_\_\_ No \_\_\_\_\_**