NEW PATIENT FORM

*Welcome to **Sydney Cosmetic Sanctuary**. Thank you for choosing to have your treatment with us. The information provided on this form is important to your health. All information provided is strictly confidential. Should you have any questions, please do not hesitate to ask.*

1. PERSONAL DETAILS

Full Name: _____

Title First Name Other given names Surname

Date of Birth: _____

Address: _____ Postcode:_____

Occupation: _____ Employer: _____

Telephone – Home: (__)_____ Work: (__)_____ Mobile: _____

E-mail Address: _____

Preferred spoken language: _____ Do you require an interpreter? _____

When and where are the best times to contact you? _____

Who may we thank for referring you? _____

EMERGENCY CONTACT DETAILS:

Name: _____ Relationship: _____ Contact Number: _____

2. BILLING DETAILS

Billing Address: _____Postcode_____

Medicare Card Number: _____ Position on Card: (__) Expiry: ___/____

Name of Private Health Fund: _____ Membership Card Number: _____

DVA Card No:(if applicable) _____ Pension Card No:(if applicable) _____

3. FURTHER INFORMATION

Name of General Practitioner (GP):_____ Phone: (__)_____

Name of Referring Doctor (if applicable): _____ Phone: (__)_____

4. HOW DID YOU HEAR ABOUT US? (Please provide details)

Internet – which site?: _____Social Media: Facebook/Instagram (please circle)

Magazine Advertisement/Story – which one?: _____ TV Show – which one?: _____

Other (please provide details): _____

5. OUR SERVICES *(Please tick if you would like to know more about the following)*

Plastic Surgery: Face ☐ Breast ☐ Body ☐ Antiwrinkle Injections ☐ Fillers ☐ Other ☐

Dentistry: Teeth Straightening ☐ Whitening ☐ Smile Makeover ☐ Other ☐

MediSpa: Skin Advice ☐ Peels ☐ Skin Needling ☐ Bodysculpting ☐

SYDNEY COSMETIC SANCTUARY

6. MEDICAL HEALTH HISTORY

Are you currently taking any medications, pills, herbal supplements or vitamins? Yes / No

If yes, please list name and dosage: _____

Do you smoke? Yes / No

If yes, how many per day? _____

Do you drink alcohol or take recreational drugs? Yes / No

If yes, which and how much? _____

Are you aware of having an allergic (or adverse) reaction to any medications, antibiotics, anesthetics, iodine, sticking tapes or any other substances? Yes / No

If yes, please list: _____

Have you been admitted to hospital in the past five years? Yes / No

Reason for visit: _____

Height:_____ **Weight:** _____ Have you previously had a significant weight fluctuation or change? If yes, please provide details:

_____

Please indicate which of the following you have had, or have at present. Circle 'yes' or 'no' to each item.

High Blood Pressure	Yes / No	Hepatitis/HIV	Yes / No
Diabetes	Yes / No	Liver Disease	Yes / No
Heart Pacemaker	Yes / No	Kidney Trouble	Yes / No
Heart Disease/Attack/Surgery	Yes / No	Gall Bladder Trouble	Yes / No
Chest Pain/Lung Disease/Asthma	Yes / No	Hiatus Hernia/Stomach Ulcers	Yes / No
Thyroid Problems	Yes / No	Rheumatoid Arthritis	Yes / No
Stroke/Epilepsy	Yes / No	Tuberculosis	Yes / No
Schizophrenia/Bipolar Disorder	Yes / No	Fainting/Dizzy Spells	Yes / No
Depression/Anxiety	Yes / No	Radiation/Chemo Therapy	Yes / No
Anemia/Excessive Bleeding	Yes / No	Tumours	Yes / No
Abnormal bruising or scarring	Yes / No	Artificial Joints (hip, knee etc.)	Yes / No
Latex Allergy	Yes / No	Snoring or Sleep Apneoa	Yes / No
Haemophilia	Yes / No	Blood Clots/DVT	Yes / No

Do you have or have you had any disease, condition or problem not listed?

If yes, please list: _____

For Women - are you: Pregnant? Yes – How many Months: _____ / No **Nursing?** Yes / No

Taking birth control pills? Yes / No

SIGNATURE & CONSENT

I understand that, to the best of my knowledge the questions on this form have been accurately answered. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status or condition.

I hereby authorise the team at Sydney Cosmetic Sanctuary to perform all necessary procedures that I may need, with my informed consent. I also give permission to the Doctors or the staff at Sydney Cosmetic Sanctuary to use any clinical photos for lecturing, publishing or educational purposes.

I understand the above information is necessary to provide me with treatment in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature: _____ Date: _____

☐ Please tick this box, should you **NOT** wish for us to correspond with your referring doctor or general practitioner.

☐ Please tick this box, should you **NOT** wish for us to publish/use any clinical photos for the purposes stated above.

To make your visit more comfortable, we have a selection of complimentary beverages available for you. Please ask one of our practice receptionists to supply you with our list.