Dr Simone Matousek
Plastic, Reconstructive & Cosmetic Surgeon
FRACS (Plast), MBBS (Hons), PhD

NEW PATIENT INFORMATION

Mr/Mrs/Ms/Miss/Dr/Other _____
Title (Circle one) **First Name** **Middle Initial** **Surname**

Address:_____

Suburb:_____ **State:**_____ **Postcode**:_____

Home Phone:_____ **Work Phone:**_____

Mobile:_____ **Date of birth:** _____/_____/_____

Email: _____

Medicare No:_____**Ref on Card:**_____ **Expiry:**_____

Private Health Fund:_____ **Membership No:**_____**ref:**_____

Heath Care/Pension/DVA Card Number:_____ _____
(Please Circle)

Aged Pension/DVA/Other: _____

Reasons for seeing Dr Simone Matousek?_____

_____

How did you hear about us? (Please Circle): **DOCTOR/GP** **FRIEND** **INTERNET SEARCH**
ADVERTSING **OTHER:**_____

Referring Doctor: _____ _____
Specialist/GP referral (circle one)

Usual General Practitioner: (If different from above)

Name: _____ _____

Address: _____ _____

Contact Number:_____

Level 1, Hemsley House, St Luke's Hospital, 18 Roslyn Street, Potts Point NSW 2011
W. drsimonematousek.com E. simone@drsimonematousek.com
T. (02) 9332 3088 F. (02) 8072 2110

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Medical problems(e.g asthma, diabetes, high blood pressure)_____

_____

_____

Are you a smoker? (Please Circle) **YES or NO**

Alcohol intake: (Please Circle) **DAILY WEEKLY OCCASIONAL**

Do you have a history of clotting disorders or bleeding?
(Please circle) **NO or YES (Give details)**

_____

Do you have a history of clots in the leg (Deep Vein Thrombosis) or clots in the lung (Pulmonary Embolism)?
(Please circle) **NO or YES (Give details)**

Do you have a family history of clots in the leg or lung? (Please circle) **NO or YES**

Past cosmetic non-surgical procedures (Eg Botox, fillers, laser) date, location, product, amount:

_____

_____

Past plastic surgery procedures listing date, location, surgeon:

_____

_____

Other past operations:

_____

_____

Current Medications: _____

_____

Herbal Medications/dietary supplements eg: fish oil/gingko biloba?

_____

Allergies: _____

_____

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CONSENT TO COLLECT PATIENT INFORMATION

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. We will use the information you provide in the following ways:

1) Administrative purposes in running our medical practice.
2) Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3) Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice as advised by you.

I understand the reasons why my information must be collected.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any purpose other than the above, my consent will be sought.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

Signed _____ Date: _____

Patient Name (Please print) _____

CONSENT FOR COLLECTION AND USE OF PHOTOGRAPHS AND PATHOLOGY

Please circle all which apply:

I permit Dr Matousek to use de-identified (pre and post operative) photos of myself: By de-identified this means eyes and other distinctive features of the face blacked out, distinctive moles, birthmarks or tattoos removed.

a) on the business website **YES NO**

b) in clinical research papers (only seen by other surgeons in scientific journals) **YES NO**

c) to show other patients **YES NO**

I permit Dr Matousek to use my anonymous pathology (microscope slides) and radiology results (mammograms/CTs/ MRIs) in published research papers (seen only by other surgeons in scientific journals).

Signed_____ Date_____

Patient Name (Please print)_____

FRACS Fellow of the Royal Australasian College of Surgeons
Member AUSTRALIAN SOCIETY OF PLASTIC SURGEONS
IFATS
Australasian Society of Aesthetic Plastic Surgery
ISAPS
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