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

Pronouns (Circle one) She/her, He/him, Them/They, prefer not to say, Other _____

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:**____

Covered for private hospital cover: YES or NO

Occupation: _____

Reasons for seeing Dr Simone Matousek?_____

_____

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

Current Medications: _____

_____

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

_____

Allergies: _____

_____

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**

Other significant family history- cancers, genetic diseases

_____

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

_____

_____

Past plastic surgery procedures listing date, location, surgeon:

_____

_____

Other past operations:

_____

_____

_____

Please turn over.

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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) _____

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CONSENT FOR COLLECTION AND USE OF PHOTOGRAPHS AND PATHOLOGY

Comparing before and after photographs is a necessary part of establishing the efficacy of a given treatment. Prior to any surgical or non-surgical procedure, photographs will be taken and stored in a confidential and secure manner.

It can be very helpful for other patients to see previous results when considering surgery. We understand the importance of protecting your privacy. As such, any photography approved by you for use will ensure you are not identifiable. The de identification process includes blurring distinctive facial features not relevant to the results, removing distinctive skin markings such as freckles, moles or tattoos.

If you do decide to allow your images for any of the purposes listed below, you will retain the right to review and approve the images before they are published or used in any capacity. If you wish to withdraw this photography consent at any time, you are able to do so.

Please answer Yes or no to the below uses

I permit Dr Matousek to use de-identified (pre and post operative) photos of myself. By de-identified this means blurring distinctive facial features not relevant to the results, removing distinctive skin markings such as freckles, moles or tattoos and also allowing you to approve the photos prior to publication.

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

b) social media platforms **YES** **NO**

c) in clinical research papers published in journals and presentations at surgical conferences (only seen by other surgeons) **YES** **NO**

d) to show other patients coming for consultation (in rooms only, no ongoing access to your images) **YES** **NO**

The next section pertains to pathology and radiology results which are completely deidentified. This include pathology (histopathology microscope slides) and radiology results (mammograms/CTs/ MRIs) in published research papers (seen only by other surgeons in scientific journals). YES NO

Signed_____ **Date**_____

Patient Name (Please print)_____

FRACS Fellow of the Royal Australasian College of Surgeons
Member Australian Society of Plastic Surgeons
IFATS
ISAPS International Society of Aesthetic Plastic Surgery

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