# PLASTIC SURGERY AUCKLAND
## Cosmetic & Reconstructive Plastic Surgery

**Murray Beagley** FRACS (Plast), MBChB, Dip Hand Surg (Euro)

*We have pleasure in welcoming you to Plastic Surgery Auckland and trust you will be totally satisfied with the personalised service and high quality care you receive. If you have any questions please do not hesitate to discuss these with us.*

*It is essential for your medical safety and surgical outcome that you provide us with an accurate and complete medical profile. Therefore, please fully complete the following pages, ensuring you list all your current medications, allergies, current health condition and all past surgeries.*

Please also note the following details regarding payment of accounts and sign to indicate your agreement to these conditions

- A consultation fee is payable by you for today's appointment, as are any fees for additional services provided today. We accept cash, cheques and most credit cards.

- We require a prior approval number prior to surgery, if your account is to be paid by your insurance company. Make sure you understand your particular insurance cover, as you are responsible for any shortfall in such cover. If your insurance company requires a special medical report, there will be a charge for this service.

- A late payment fee of $25 per month will be added if your account balance remains unpaid after 60 days for whatever reason. Collection recovery costs may also be added.

- I have read and accept the above conditions

Signed: _____ Date: _____

**Suite 6, 9 St. Marks Road, Remuera, Auckland, Ph: 09-529 2029, Fax: 09-529 2025**

# PATIENT REGISTRATION *(please print)*

Today's date: ___ / ___ / _____

Patient Surname: _____ First name(s): _____

Please circle: Mr / Mrs / Miss / Ms / child Male / Female

Date of birth: ___ / ___ / _____ Country of birth: _____

Address: _____

_____

Phone: Home: _____ Work: _____ Mobile: _____

email: _____

ACC Claim Number _____ Date of accident: ___ / ___ / _____
(if applicable)

Name of GP: _____

Address of GP: _____

It is our usual practice to write to this GP after a consultation. If you have a specific reason why you do not wish us to do so please circle: **NO**

If referred to us be a doctor other than the GP above, give the doctors name: _____

Contact in case of emergency _____ Relationship _____

Address _____ Phone _____

Name & address of your employer _____

_____ Phone _____

Occupation: _____

Reason for today's appointment: _____

How long have you had **symptoms** / this condition? _____

Have you ever **smoked**? Yes / No If yes, when did you quit, or how many per day now? ____

Are you **pregnant**? Yes / No How many pregnancies have you had? _____

List all **previous surgeries**, with dates e.g. tonsils, hernia, cosmetic:

_____

_____

List all **medical problems** or **major illnesses** you have had:

_____

_____

List all **medications** you are now taking (including Aspirin, vitamins, prescription or over-the-counter)

_____

_____

List any **allergies** or **sensitivities** e.g. Sulphur, Penicillin, Elastoplast, Codeine etc:

_____

Have you ever had any problems with **anaesthesia**? Yes / No

Do you, or anybody in your family have a history of **bleeding disorders**? Yes / No

Do you take **Vitamin E, Aspirin, Disprin, Warfarin**, or any non-steroidal, anti-inflammatory medications which can "thin" the blood or reduce blood clotting time? Yes / No

Have you ever had a **blood transfusion**? Yes / No

**Have you ever had any of the following?** (please tick)

| | | | | | |
|---|---|---|---|---|---|
| Heart trouble | | Ankle Swelling | | Rheumatic Fever | |
| Faints/Turns' | | Blood Pressure/Stroke | | Chest Pain | |
| Tuberculosis | | Asthma | | Pheumonia | |
| Persistent Cough | | HIV/AIDS | | Diabetes | |
| Epilepsy | | Hepatitis | | Any infectious diseases | |

How did you hear about us: Referral / Yellow Pages / Internet / Friend / Magazine

(which?_____) or other_____

Signature of Patient

(or guardian, if under 18 years) _____ Date: ___ / ___/ _____