Dr. André Safvat MBBS FRACS
Plastic & Reconstructive Surgeon

Personal Details

Title *(please circle)*:

First Name:_____ Surname: _____

Address: _____

Date of Birth: _____ Occupation: _____

Phone (mobile): _____ Phone (other): _____

Email address: _____

Emergency Contact Name:_____

Relationship: _____Phone:_____

Are you happy for us to discuss medical information, appointments & accounts with this person: YES☐ NO ☐

On occasion, we will send emails related to our practice, medical information, updates etc. If you do not want to receive these emails, please tick here ☐

How did you hear about Dr Safvat? Please tick:
GP / Doctor ☐ Friend / Family / Word of Mouth ☐ Social Media ☐ Internet / Website ☐
Name: _____

Medicare & Insurance Details

Medicare Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Exp Date:_____

Number next to Your Name on Medicare Card:

Private Health Fund:_____ Membership Number: _____

Veterans Affairs Type: _____ Veterans Affairs Number:_____

Agreement & Signature

Privacy agreement – In order to comply with the Privacy Laws (Privacy Act Amendments – Private Sector – Act 12/3/2014) your agreement to the following statement is required (patient or parent to complete):

I agree to allow Dr Safvat and his staff access to all relevant information regarding my medical conditions. I understand that they may be required to forward information about my medical condition or history to other health care providers. I understand that to provide the highest medical care, my clinical records may be accessed or reviewed by staff in this practice.

Photograph Policy:
I agree that clinical photographs may be taken by Dr Safvat or his staff as part of my consultation to be kept with my confidential medical records within this Practice YES☐ NO☐

I agree that my unidentifiable clinical photographs may be used for research, medical education or public education purposes YES☐ NO☐

Signed: _____ Date: _____

Please complete reverse side of form

Past Medical History

Do you have or have you ever had any of the following medical conditions? Please circle Yes or No

ANGINA (heart pain) or Heart Attack ..... YES NO
HYPERTENSION (high blood pressure) ..... YES NO
STROKE or Temporary Weakness on one side ..... YES NO
DIABETES (high blood sugar) ..... YES NO
RENAL DISEASE (kidney disease) ..... YES NO
RESPIRATORY ILLNESS (lung problems ..... YES NO
BLEEDING DISORDER or Clotting issues ..... YES NO
HEPATITS (liver virus or disease) / HIV / AIDS ..... YES NO
CANCER ..... YES NO
CHICKEN POX or SHINGLES ..... YES NO
RECENT VIRAL ILLNESS (Flu-like) ..... YES NO
Other INFECTIONS (such as MRSA VRE etc) ..... YES NO

If you answer YES for any of the above, please describe your treatment:

_____

_____

Do you smoke, if so how many per day? _____

Do you have problems with scarring / healing of wounds? YES NO If yes, please specify:

_____

Please list any operations you have had:

_____

_____

Have you had any difficulties with the anaesthetics?

_____

Did you suffer any complications related to your operations?

_____

If you have a condition not listed above, please describe:

_____

_____

Do you currently take any medication (prescription or over the counter or herbal)?

_____

_____

_____

_____

Are you allergic to any medications? YES NO If yes, please specify:

_____

_____

Medical Contact Details

GP Name: _____ Suburb: _____

Other Specialists: _____