DR MIROSHNIK REGISTRATION FORM

Personal Details

NAME: Miss / Ms / Mrs / Mr / Dr _____
GIVEN NAME(S) SURNAME

SEX: □ Male □ Female DATE OF BIRTH _____/_____/_____ AGE: _____years

POSTAL ADDRESS_____

_____ Post Code _____

PHONE (H) _____ (M) _____ (W) _____

EMAIL ADDRESS _____

OCCUPATION _____

EMERGENCY CONTACT_____ RELATIONSHIP_____

CONTACT NUMBER (in case of emergency) _____

PREFERRED METHOD OF CONTACT/CORRESPONDENCE: □ **EMAIL** □ **POST** □ **TELEPHONE**

How did you hear about Dr Miroshnik? (Tick all that apply)

□ Internet Search □ Facebook □ GP □ Specialist/Other Health Professional

□ Television □ Magazine □ Other _____

□ Word of Mouth- Referred by _____

HAVE YOU VISITED OUR WEBSITE www.drmiroshnik.com.au? □ **YES** □ **NO**

HAVE YOU LIKED THE DR MIROSHNIK FACEBOOK PAGE? □ **YES** □ **NO**

Referral Details (where applicable)

REFERRING DR'S NAME_____ ADDRESS_____

_____

IS THIS DOCTOR YOUR USUAL GP? □ Yes □ No

Name of GP (if different) _____ ADDRESS_____

_____

Health Insurance Details

MEDICARE NUMBER_____POSITION NO_____EXPIRY_____/_____

DO YOU HAVE PRIVATE HEALTH INSURANCE? □ **YES** □ **NO**

IF YES, NAME OF FUND _____ MEMBER NUMBER_____

VETERAN AFFAIRS NUMBER (if applicable) _____

IS THIS VISIT RELATED TO A WORKER'S COMPENSATION CLAIM? □ **YES** □ **NO**

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Medical History

1) CURRENT HEIGHT: _____ CURRENT WEIGHT: _____

2) DO YOU SMOKE? ◻ **YES** ◻ **NO** If yes, how much? _____

3) ALCOHOL INTAKE: □ NIL □ OCCASIONALLY □ WEEKLY □ DAILY

4) ARE YOU ALLERGIC TO ANYTHING? ◻ **YES** ◻ **NO** If yes, please specify _____

5) DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING MEDICAL PROBLEMS? (Please tick all that apply)

□ Asthma	□ Diabetes	□ Immune Disorders	□ Cancer	□ High Blood Pressure
□ Epilepsy	□ Bacterial Infections	□ Heart Problems	□ Viral Infections	□ Bleeding Disorders
□ Cold Sores	□ Blood Clots/DVT	□ Bad scarring	□ HIV/AIDS	□ Hepatitis B or C
□ Arthritis	□Thyroid Disease	□ Psychiatric Treatment		

6) LIST ANY MEDICAL PAST OR PRESENT MEDICAL PROBLEMS/CONDITIONS: _____

_____

_____

7) LIST ANY PREVIOUS OPERATIONS/SURGERIES THAT YOU HAVE HAD: _____

_____

_____

8) LIST ANY REGULAR MEDICATIONS THAT YOU TAKE (including vitamins/homeopathics etc): _____

_____

_____

9) HAVE YOU HAD ANY CHILDREN? ◻ **YES** ◻ **NO** IF YES, HOW MANY? _____

10) ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING? ◻ **YES** ◻ **NO**

Which treatments and/or procedures are you interested in?

□ Breast Augmentation	□ Rhinoplasty
□ Breast Lift/Reshaping	□ Facial Surgery
□ Breast Reduction	□ Other Surgical
□ Breast- Other	□ Injectables (ie. anti-wrinkle injections, dermal fillers)
□ Tummy tuck	□ Skin consultation/facial assessment
□ Liposuction	□ Laser/light treatments
□ Labiaplasty	□ Exilis for skin tightening/body contouring
□ Post Pregnancy Makeover	□ Other _____