DR JOHNNY KWEI
PLASTIC SURGERY

DR JOHNNY KWEI
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New Patient Information Form

Name Title	Given Names		Surname	
DOB (DD/MM/YYYY)			Age	
Home Address			Suburb	Postcode

Preferred Contact (Please tick):

○ Home Phone Number: ○ Mobile Number: ○ Work Phone Number:

I can be contacted via (tick all that apply)

○ Mail ○ SMS / Voice mail ○ Email:

Emergency Contact Name:		Relationship:	Phone Number
Referring Doctor	Name of GP (if different)		Location
Medicare No.	Your position on the card		Expiry Date
Private Health Fund	Membership No.		Position
Occupation			

Health Questionnaire

Height (Cm): Weight (Kg): Daily Smoking Intake (Cigarette): Daily Alcohol Intake (Glass):

Do you have any significant medical problems the Surgeon should know about?

Have Past / Family history of bleeding? you had any operations previously (including cosmetic surgery?

Have you previously used steroids / cortisone?

Are you allergic to any meadications? Please specify:

Are you allergic to dressings?

Do you have a history of the following? (Please tick)

○	Asthma	○	Rheumatic Fever	○	Spinal / Neck Problems	○	Blood Clots
○	Diabetes	○	Hepatitis	○	Healing Problems	○	Arthritis
○	High Blood Pressure	○	HIV / AIDS Exposure	○	Bad Scarrings	○	Wound Infections
○	Heart Trouble	○	Psychiatric Treatment	○	Contact Lenses / Prescription Glasses		

Workcover Insurance

Provide your WorkCover Insurance Fund		Claim No.
Date of Injury	Name of Case Manager	Manager Phone No.

How did you hear about us? (Please tick)

○ GP / Specialist: ○ Google ○ Family /Friend ○ Vogue Magazine ○ Hospital ○ Other:

Consent (Please tick Yes or No)

I give permission for clinical photographs to be taken as part of my consultation	○	Y	○	N
My clinical photographs may be used for medical education purposes (doctors/nurses/medical students only)	○	Y	○	N
My clinical photographs may be used for public education purposes	○	Y	○	N
My clinical photographs may be used in social media & for marketing purposes. My name, face or any body tattoos will NOT be shown	○	Y	○	N
I give permission for my consultation details to be used in communication with other health care professionals who are involved	○	Y	○	N
I would like to receive any promotional products or treatments that the practice may offer in the future	○	Y	○	N

Patient / Guardian Signature	Date
Print Full Name	