Bernard Carney

MBBS, BMedSci(Hons), FRACS (Plas), OAM

SPECIALIST PLASTIC, COSMETIC
& RECONSTRUCTIVE SURGEON

Please complete this form in preparation for your consultation

Personal details

Title: ________ Surname: ______________________________ First name: ______________________________

Postal address: ____

Suburb: ______________________________ State: ________ Post Code: ______________

Date of birth: ___/___/___ Occupation: ______________________________

Phone number: (H) ______________ (W) ______________ (M) ______________

Do you allow us to send SMS/ leave a message regarding your appointments? ☐ Yes ☐ No

Email address: ____

Next of kin: ______________________ Relationship: ______________ Phone No: ______________

Memberships

Medicare number: ______________ Ref No: ________ (# next to your name) Expiry date: _____/_____

Do you have private health insurance? ☐ Yes ☐ No - (I am self funded/Uninsured)

Health fund: ______________________________ Membership number: ______________________________

Does your cover include: ☐ Hospital Cover ☐ Extras ☐ Unknown

***If under 18;** Account holders name: ____

Date of birth: ___/___/___ Ref on Medicare card: __________

Do you hold an Age Pension card? ☐ Yes ☐ No Membership number: ______________________________

Department of Veterans Affairs card? ☐ Yes ☐ No DVA number: ______________ Colour: ☐ White ☐ Gold

Medical conditions

Do you have any alergies / sensitivities? ☐ Yes ☐ No Please list: ______________________________

Other

Local / Usual General Practitioner: ____

Clinic: ____

Signed: ____ **Date:** ___/___/___

By signing above you acknowledge you have had the opportunity to view the fees (over page) and privacy policy and rights and responsibility.