DR GARRY BUCKLAND

Please fill in this form and bring it to your initial consultation.

Title:	Surname:	First Name:
Address:		
Suburb:	State:	Postcode:
Phone (Home):	Phone (Mobile):	Phone (Work):
Email:	Date of Birth:	Occupation:

Medicare No:	No on Card:	
Veterans Affairs No:	Health Fund:	Member No:

Next of Kin:	Relationship:	Phone:

Local GP:	GP's Address	
GP's Suburb:	GP's State:	GP's Postcode:

How did you hear about us? ☐ Friend ☐ Advertising ☐ Referring Doctor ☐ Website ☐ Other

List current medications

Do you smoke? ☐ Yes ☐ No	How many per day?
Allergies:	

Declaration

I understand clinical photographs may be taken	☐ Yes	☐ No
I give permission for clinical photographs to used for medical education	☐ Yes	☐ No
I give permission for clinical photographs to be used for patient education	☐ Yes	☐ No
I give permission for these details to be used in communication with other health professionals	☐ Yes	☐ No
I give permission for Dr Buckland to contact me via email and post	☐ Yes	☐ No
I have read the Patient Privacy Policy document	☐ Yes	☐ No

Important Notice: Photographs taken will not be used for external marketing purposes (online, in print or otherwise)

PAYMENT IS DUE AT TIME OF CONSULTATION, THANK YOU

Signature	
X	Date / /

B.Med (Hons), FRACS (Plast)
Specialist Plastic Surgeon

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