

Surgeon you are seeing today:

Mr Mark Hanikeri

Mr James Savundra

Mr Rohan Page

Mr Vijith Vijayasekaran

Mr Anthony Williams

Mr Lip Teh



WESTERN AUSTRALIAN
PLASTIC SURGERY CENTRE

PERSONAL DETAILS

Mr, Mrs, Miss, Ms, Other: _____
Surname Given Names

Previous Surname: _____ Marital Status: _____

Address: _____

Suburb: _____ State: _____ Post Code: _____

Postal Address (if different from above): _____

Telephone: (Home) _____ (Work): _____

Mobile: _____ Email: _____

Date of Birth: _____ Occupation: _____

EMERGENCY CONTACT DETAILS

Next of Kin: _____ Relationship: _____

Telephone: (Home) _____ (Work/Mob): _____

Medicare No: **Card Reference No:** **Expiry Date:** /
(Number next to name)

Do you have Private Hospital Insurance? Yes No **Type of cover:** Hospital Ancillary

Name of Fund: _____ **Membership No:** _____

Pension/HCC No: _____ **Expiry Date:** _____ / _____ / _____

Veteran Affairs Card No: (letters followed by numbers): _____ **Gold / White**

REFERRAL DETAILS

Referring Doctor: _____ **Suburb:** _____ **Date of Referral:** _____

Usual Doctor: _____ **Suburb:** _____

How did you find out about us? (Please circle your answer) GP/Specialist Internet Yellow Pages Friend Other

* I agree that I am responsible for the payment of all fees to the above indicated surgeon for consultation, surgery, or any reports requested on my behalf for medico-legal reasons.

* I consent to the collection of this information, for the primary purpose of providing quality health care. The information will be also used for administrative, billing and debt collection purposes, and for referrals and requests regarding your healthcare. Should your surgeon wish to use your information for research and educational purposes, he will discuss this with you during your consultation.

Signature: _____ **Date:** _____

For Workers Comp, Insurance, and 3rd Party Details P.T.O

**FOR WORKERS COMPENSATION INJURY,
PLEASE COMPLETE THIS SECTION**

Name of your employer: _____

Address of your employer: _____

_____ Telephone: _____

Date of Accident / Injury: _____

Employers Insurance Company: _____

Claim Number: _____

*Should this be a new injury and you do not know these details, please check with your employer and telephone your surgeon's rooms with this information as soon as possible. **Otherwise the account may be forwarded to you.***

**FOR MOTOR VEHICLE ACCIDENT INJURY,
PLEASE COMPLETE THIS SECTION**

Date of Accident / Injury: _____

Claim Number: _____

Did your accident happen in WA? Yes

No

If your claim is not accepted by the insurance company, you will be liable for any invoices raised in the course of your treatment.

AUTHORITY FOR THE RELEASE OF INFORMATION

I _____ (name) give permission for you to forward confidential information regarding my injury, the treatment I have received and guidelines for return to work to my employer, insurance company and rehabilitation provider.

Signature: _____ Date: _____

This signature confirms that I have read the above statement and that I understand and agree with it.