

Surgeon you are seeing today:

Dr Brigid Corrigan
Mr James Savundra
Mr Lip Teh
Mr Anthony Williams

Mr Mark Hanikeri
Mr Rohan Page
Mr Vijith Vijayasekaran



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 / NEXT OF KIN 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: _____

Blue Pension Card 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 INJURIES

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 INJURIES

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.