

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:** \_\_\_\_\_

**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 3<sup>rd</sup> 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.