WORKERS COMPENSATION INJURIES

PLEASE COMPLETE THIS SECTION

Employer Name: _____

Employer Address: _____

Telephone: _____ Employer Injury Manager Name: _____

Employer Injury Manager Contact Details: _____

Employers Insurance Company: _____ Claim Number: _____

Injury Date: _____ Injury Time: _____ Geographic Location: _____

How did it happen? _____

Type of Injury (eg. *Left hand laceration*) _____

Should this be a new injury & you do not know these details, please check with your employer and phone our rooms as soon as possible with this information

Failure to do so may result in the account being forwarded to you

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.

Surgeon you are seeing today:

Dr Brigid Corrigan	☐	Mr Mark Hanikeri	☐
Mr Rohan Page	☐	Mr Lip Teh	☐
Mr Vijith Vijayasekaran	☐	Mr Anthony Williams	☐

WESTERN AUSTRALIAN
PLASTIC SURGERY CENTRE

PATIENT DETAILS

Mr, Mrs, Miss, Other: _____

Surname Given Names

Previous Surname: _____ Marital Status: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

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): _____

Patient Medicare No: ☐☐☐☐ ☐☐☐☐☐ ☐ **Card Reference No:** ☐ **Expiry Date:** ☐☐/☐☐☐☐

ACCOUNT HOLDER FOR PATIENT UNDER 18

Parents Name: _____ **Date of Birth:** _____

Parent Medicare No: ☐☐☐☐ ☐☐☐☐☐ ☐ **Card Reference No:** ☐ **Expiry Date:** ☐☐/☐☐☐☐

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

Name of Fund: _____ Membership No: _____

Blue Pension Card No: _____ Expiry Date: _____/_____/_____

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

REFERRAL DETAILS

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

Usual Doctor: _____ Practice Name: _____

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 also be 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