Doctor you are seeing:

Dr Steven Clarke	☐	Dr Brigid Corrigan	☐
Mr Mark Hanikeri	☐	Mr Rohan Page	☐
Mr Nathan Stewart	☐	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 Health Insurance with Hospital Cover? ☐ **Yes** (enter details below) ☐ **No I only have Ancillary Cover**

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: ____________________

CONSENT

* 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 acknowledge that I have read and understand the information provided in the Western Australian Plastic Surgery Centre's Privacy Policy (available online at www.plasticsurgerycentre.com.au/privacy-policy or in hard copy upon request). I provide consent for the Western Australian Plastic Surgery Centre to collect, use and disclose my information as outlined in the Privacy Policy.

Signature: ______________________________ Date:____________________

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

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.