Mr / Mrs / Ms / Dr / Prof / Other: _____

Given Name: _____ *Surname:* _____

*Address:*_____ *Postcode:* _____

Phone: _____ *Mobile:* _____ *Work:*_____

DOB: _____/_____/_____ *Age:* _____ *Occupation:* _____

Medicare Number: _____ *Exp:* ___/____ *Ref:*_____ *Are you in a Health Fund? YES/NO*

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

*DVA No: :*_____

*Email address:*_____

Emergency Contact: _____ *PH:*_____ *Relationship:*_____

Referring Dr and Address: _____

Local GP and address (if different from above: _____

Is this consultation in respect of worker's compensation? YES / NO

Insurance Company:_____ Address: _____

Date of Injury: _____/_____/_____ Claim No: _____

Case Manager Name: _____ PH: _____ Email: _____

Employer: _____ Address: _____

Has you claim been accepted? YES / NO

Have you approached a solitcitor regarding this injury? YES / NO

Solitictor: _____ Address: _____

Do we have authority to forward reports to your solicitor/ insurance company? YES / NO

Current Medications:

_____

_____

_____

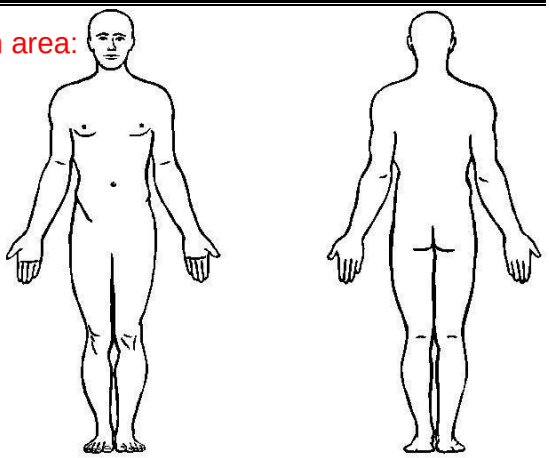
_____

_____

_____

Allergies: _____

Please circle your problem area:



ACKNOWLEDGEMENT:

In consideration of A/Prof Michael Neil and/or Dr Amir Kalanie, providing medical services requested by me:

I acknowledge that am personally liable for the doctors' fees and charges in relation to all treatment provided by him to me and for the preparation of any medical or any other reports or accounts requested by any doctor, solicitor, or agent acting on my behalf. I understand that my liability for the payment of my account is not dependent upon the success of any workers compensation or other insurance litigation in which I am currently involved or which I may commence in the future because of my injuries or illnesses:

Signed: _____