DR ARUL BALA

Suite 1 / 129 Grand Boulevard
Joondalup WA, 6027
TEL: 9301 8300
arulbalaneuro@outlook.com

PERSONAL DETAILS

Dr / Mr / Master / Mrs / Ms / Miss / Other (Circle one)

First Name: _____ Surname: _____

Date of Birth: _____ /_____ /_____ Occupation: _____

Address: _____

Suburb: _____ Postcode: _____

Phone - Home: _____ Phone - Work: _____

Phone - Mobile: _____ Email: _____

Country of Birth _____ Marital Status _____

EMERGENCY CONTACT/NEXT OF KIN DETAILS

Next of Kin: _____ Relationship: _____

Phone – Home: _____ Phone – Mobile: _____

***Medicare No.:** ☐☐☐☐ ☐☐☐☐☐ ☐ **Ref No.:** ☐ **Expiry:** ☐☐/☐☐

(Number next to name, on the left hand side)

Centerlink Healthcare_____ **Pension Card No.:**_____

Do you have Private Health Insurance? With Hospital cover YES / NO (please circle)

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

When did you join your Private Health Fund (Approx.): _____

Dept. of Veterans' Affairs Card No.: _____ ☐ **Gold Card** ☐ **White Card**

Please list the location of any previous scans done _____

REFERRAL DETAILS

Referring Doctor: _____ Suburb: _____

Usual Doctor (GP): _____ Suburb: _____

Please note this clinic requires payment on the day of consultation, we can submit your account to Medicare for your rebate electronically for your convenience at your request. Failure to meet financial obligations may result in your account being submitted to our debt collection agency at your further costs. You must advise the clinic of cancellations 24 hours prior to a consultation or you will be charged the 'Did not attend" fee.

Patients must give their consent (implied, oral or written) for personal information to be collected & used as required by the Privacy Act 1988.

I provide my consent for Joondalup Sessional Suite to collect, use and disclose my personal information as required by the Privacy Act 1988 (*Patient Consent to Collect and Disclose Information is available for your perusal on request)*

Signature: _____ Date: _____

FOR WORKERS' COMPENSATION & MOTOR VEHICLE ACCIDENT PATIENTS, PLEASE COMPLETE OVER PAGE

THIS SIDE <u>ONLY</u> APPLIES TO WORKERS COMPENSATION & MOTOR VEHICLE ACCIDENT CLAIMS

<u>FOR WORKERS COMPENSATION INJURY</u>

Your Employer's Details:

Name of Employer: _____

Address: _____

Contact Number: _____

Date of Accident: _____

Employer's Insurance Company: _____

Your Claim Number with this Insurance Company: _____

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. If your Claim is not accepted by the Insurance Company, you will be liable for any invoices raised in the course of your treatment.

<u>FOR MOTOR VEHICLE ACCIDENT INJURY</u>

Date of Accident/Injury: _____

Claim Number: _____

Did your accident happen in WA? ☐ YES ☐ NO

<u>AUTHORITY FOR THE RELEASE OF INFORMATION</u>

I _____ (your 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.