ALLEN CHONG
MBBS (UNSW), FRACS (Orth.)
Orthopaedic Surgeon
ABN 120 92 201 682
GENERAL ORTHOPAEDIC SURGERY
Arthroscopic Surgery

FOR WORKERS COMPENSATION INJURY PLEASE COMPLETE THIS SECTION:

Name of your Employer: ____

Address of your Employer: ____

____

Phone Number of Employer: ______________________

Date of Accident or Injury: ______________________

Name of the Insurance Company that your Employer uses: ____________________________

Claim Number: ______________________

Should this be a new injury and you do not have these details, you will be held responsible for all fees and charges and will be billed at the time of consultation. You will then need to recoup the cost from the insurance company.

FOR MOTOR VEHICLE ACCIDENT INJURY PLEASE COMPLETE THIS SECTION:

Date of Accident or Injury: ____

Claim Number: ____

AUTHORITY FOR THE RELEASE OF INFORMATION:

I ____(name)
give permission to forward information regarding my injury, the treatment that I have received, and guidelines for return to work to my employer, insurance company and rehabilitation provider.

SIGNED:____**DATE:**_____________

(This signature confirms that I have read the above statement and both understand and agree with it)