



Dr Michael Biggs MBBS FRACS MBA AMA(M)

Acquaintance Form

Neurosurgeon | Brain Surgery | Spinal Surgery | Nerve Surgery

Title (please circle): Mr / Mrs / Miss / Ms / Dr	Given Names:	Surname:	
Date of Birth: DD / MM / YYYY	Age:	Occupation:	
Address:			
Suburb:		State:	Postcode:
Telephone:	Mobile:	Work:	
Email Address:			
Medicare Number:		Number on Card:	Expiry Date: MM / YYYY
Health Fund Yes / No	Name of Health Fund:	Health Fund Number:	
Veterans Affairs Yes / No	DVA Number:	DVA Card Colour: Gold / White	Expiry Date: MM / YYYY
Pension Yes / No	Please present your card to reception on arrival		

Referring Doctor:		Phone Number:	
Clinic Name:	Suburb:	State:	Postcode:
GP:		Phone Number:	
Clinic Name:	Suburb:	State:	Postcode:

Other Interested Parties:

Emergency Contact

Given Names:	Surname:	Relationship:
Telephone:	Mobile:	Work:

Workers Compensation / Third Party (all sections must be completed if relevant)

Insurance Company:	Claim Number:
Case Manager Name:	Case Manager Contact Number:
Case Manager Email Address:	

I agree that Dr Biggs may discuss my medical history, diagnosis and management with my GP and other relevant specialists in relation to my medical management:

- I give permission to access all my medical and health records.
- I understand that I am responsible for my account to be paid by the due date and my unpaid accounts that require follow up outside of the practice, will acquire a 30% collection fee in addition to any legal costs incurred.
- I have read and understand Dr Bigg's Privacy Policy. (<https://biggsneuro.surgery/privacy>)

PLEASE BE AWARE: Surgical procedures in this practice are based on AMA guidelines. This will result in a "gap" payable between the Schedule Fee and the AMA fee.

Signature: _____ Date: DD / MM / YYYY