Great Eastern General Insurance (Malaysia) Berhad (102249-P)
(Formerly known as Overseas Assurance Corporation (Malaysia) Berhad)
Level 18, Menara Great Eastern, 303, Jalan Ampang, 50450 Kuala Lumpur
General Line: +603 4259 8888 Fax: +603 4813 0055
Customer Service Careline: 1300-1300 88
Website: www.greateasterngeneral.com

Great Eastern
A member of the OCBC Group

Name of Patient: ____

NRIC No: ____

ATTENDING PHYSICIAN STATEMENT

1	If treatment was a result of an accident, please provide details of accident.	
	Date of Accident: ____ Time: ____________AM /PM	Nature of Accident:
2	Hospitalisation Details, please state.	
	Admission No.: ____ Date of Admission: ____ Time: ____________AM /PM	Date of Discharge: ____ Time: ____________AM /PM
3	What were the symptoms the patient complained when he /she first saw you?	
4	Please provide the date you first saw the patient for this condition.	
5	Was the patient referred to your hospital by any doctor? If yes, please indicate his / her name and address.	☐ Yes ☐ No Name: Date: Address:
6	(a) According to the patient, how long had the patient been having these symptoms prior to the initial consultation with you? (b) Based on your professional opinion, how long had the patient been having these disability / illness prior to the initial consultation with you?	
7	Had the patient previously received any treatment for above symptoms? If so, please furnish name, address of doctors and date of consultation.	☐ Yes ☐ No Name: Date: Address:
8	Has any investigation, test or procedure been performed? If so, please furnish a copy of the result.	☐ Yes ☐ No
9	What was the diagnosis?	
10	Did you inform the patient of the diagnosis? If yes, please state.	☐ Yes ☐ No Date:
11	Please advise nature of medical treatment given.	
12	For surgery/ procedure, please state.	
	(a) Nature of operation performed:	
	(b) Name of surgeon:	
	(c) Date of surgery performed	

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No.	Question	Answer
13	Has the patient previously been treated or hospitalised in this or any other hospital for this or any disease? If yes, please state.	☐ Yes ☐ No Date: Hospital/ Clinic: Disease/ Illness:
14	Any possibility of patient having relapse?	☐ Yes ☐ No
15	Any possibility that this is a pre-existing condition?	☐ Yes , Please give details. ☐ No __________ __________ __________ __________
16	Does the patient suffer from any other underlying illnesses? If yes, please provide details.	Date of diagnosis: Underlying Illness: Doctor's name & Address & Contact No:

17 Was the illness/ condition caused directly or indirectly, wholly or partly by the following condition:-

- ☐ Congenital/ Hereditary condition
- ☐ Strike/ Riot/ Insurrection
- ☐ Drug abuse/ Intoxication
- ☐ Self-inflicted injuries/ Suicide/ Attempted suicide
- ☐ Cosmetic surgery/ Dental care/ Refractive errors connection
- ☐ AIDS/ HIV/ STD/ VD
- ☐ Nervous/ Mental/ Emotional/ Sleeping Disorder
- ☐ Hazardous sports
- ☐ Pregnancy/ Childbirth/ Caeserean section/ Miscarriage/ Prenatal/ Postnatal/ Sterilization/ Infertility.
- ☐ Routine examination/ Investigatory purposes/ Preventive treatment/ Alternative treatment
- ☐ None of the above

Declaration

"I hereby certify that the information above are full, complete and true as per record from the hospital/ clinic."

____

Signature and Stamp of Attending Physician/ Surgeon

Name of Physician/ Surgeon:

Hospital:

Date: