

7. Please specify the date of first diagnosis.

8. When did you inform the patient of your diagnosis?

9. Is patient aware of having this condition prior to seeing you? Yes No

10. When did patient first consult you for the symptoms?

11. According to patient, when did he/she first notice symptoms of condition prior to seeing any doctor?

12. How long do you feel the symptoms/illness/injury have been existing prior to consulting you?

13. Was patient referred by any doctor to see you? Yes No
If yes, please state name and address of referring doctor.

14. What is the cause of illness or injury?

15. Is the condition due to pregnancy, infertility, childbirth, abortion? Yes No
If yes, please specify the condition and the approximate date of commencement.

_____ Approximate date of commencement _____

16. Is condition a congenital anomaly or a physical defect present at birth? Yes No

17. Is condition a nervous or mental disorder? Yes No

18. Is condition a result of self-destruction or intentional self-inflicted injury? Yes No

19. Has any permanent disability been suffered? Yes No
If yes, please state nature and percentage of disability suffered.

20. Any possibility of having a relapse? Yes No

21. Has patient previously seen any other doctor for symptoms or been treated for same or similar condition?
Yes No Not to my knowledge

If yes, please state when and describe. Please indicate the name and address of any consulting doctor.

22. Based on normal medically accepted pathological development of the condition, would there have existed symptoms or manifestations of the condition prior to the insured's first consultation with you?

Yes No

23. Describe surgical procedures or treatment rendered (include name and dosage if medication was given).

24. Date surgical procedures or treatment was rendered.

25. Name of Surgeon.

26. Is surgery for cosmetic reason? Yes No

27. Is surgery medically necessary? Yes No

28. Is patient still under your care for this condition? Yes No

If no, give date your service terminated.

Signature of Doctor/Surgeon

Name and Address of Clinic/Hospital (with chop)

Name and Title

Date

Please forward this form to

**Tenet Insurance Company Ltd
Claims Department
50 Raffles Place
#05-01/06 Singapore Land Tower
Singapore 048623**