REGISTRATION FORM

☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr (please tick applicable)

Surname:_________________________________ Given Name/s:__________________________

Address: Home/Work Ph:_________________________

Street address:____________________________ Mobile:__________________________

Suburb:____________________Postcode:_____ Date of Birth:_____/______/_______

Occupation:______________________________ Local Doctor:___________________________

Email:____

Next of Kin:

☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr (please tick applicable) Name:______________________________

Relationship:____________________ Ph (H):(___)______________(M):____________________

MEDICAL INFORMATION ***Please tick if you have or have had any of the following:***

☐ Diabetes ☐ Cardiac pacemaker ☐ Hearing aid

☐ Metal implant ☐ Heart ailment ☐ Epilepsy

☐ Stomach ulcer ☐ Cancer ☐ Depression

☐ High Blood Pressure ☐ Blood Clots ☐ Skin Disorders

☐ Low Blood Pressure ☐ Arthritis

☐ Allergic reaction to drugs/tapes/creams: ____

☐ Other relevant medical history? ____

Recent surgery (<2yrs): ☐No ☐Yes If 'Yes', please specify: ____________________________

Any serious illness: ☐No ☐Yes If 'Yes', please specify: ____________________________

Are you pregnant? ☐No ☐Yes If 'Yes', how many weeks? ________________________

REASON FOR VISIT

☐Low Back ☐Mid Back ☐Neck ☐Shoulder ☐Wrist ☐Hand ☐Elbow ☐Hip

☐Knee ☐Hamstring ☐Calf ☐Ankle ☐Foot ☐Other: ______________________

REFERRAL SOURCE ***How/why did you choose to come to this clinic?***

☐Live nearby ☐Signage ☐Yellow Pages ☐Website

☐Social Media: (which?) ____

☐Google/web browser search: (which?) ____

☐Referred by Health Professional: (who?) ____

☐Family/friends recommendation: (who?) ____

☐Sports Club Affiliation: (which?) ____

☐Other: (Please specify) ____

Please turn over and complete relevant section

REGISTRATION FORM

WORKSAFE (Injured at work)

Please ensure correct details and Doctors referral is presented. Please request our clinic's WorkCover Policy to inform you of your payment responsibilities.

Employer's Name: ____

Employer's Address: ____ Postcode: _______

Supervisor or contact person for WorkSafe Claim: ______________________________________

His/Her Telephone No: (___) ____________________________

Date of injury: ____/____/______ Claim Number (if known): _______________________

Employer's insurance Company: ____

TAC (Injured in motor vehicle accident)

Please ensure correct details and Doctors referral is presented. Please request our clinic's TAC Policy to inform you of your payment responsibilities.

Claim Number (if known):___________________________ Date of accident: ____/____ /____

PRIVATE (Insured/Non-insured) ***Please tick applicable***

You will be required to settle the account in full after each consultation.

Do you have private health insurance? ☐No ☐Yes

If yes, please give name of insurer: ____

Do you have extra cover for Physiotherapy? ☐Unsure ☐No ☐Yes

Name of person responsible for payment of account:

☐Self OR ☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr Name:__________________________________

Are you a Pensioner/Health Care card holder? ☐No ☐Yes Expiry Date: ____/____ /____

The above information is confidential and will not be shared with external parties.

By signing below, I agree that this information is correct and that if presenting with a WorkSafe or TAC Claim I agree to pay an administration fee of $20 per consultation.

SIGNATURE OF PATIENT: _____________________________________ **DATE:** ____/____ /____

(or Parent/Guardian if under 16 years of age)

NB Our clinic requires <u>24 hours notice</u> for any cancellations/rescheduling of appointments. Late cancellations or missed appointments will incur a $40 fee.