Kangaroo Rd PHYSIOTHERAPY

REGISTRATION FORM

Mr ❑ Mrs ❑ Miss ❑ Ms ❑ Dr ❑ (tick applicable)

Surname:_____ Given Names:_____

Address: _____Postcode __ __ __ __

Telephone Home: (___) _____ Mobile/work: _____

Date of birth: ____/____/____ Occupation: _____

Email: _____@_____Local Dr:_____

Next of Kin:
Mr ❑ Mrs ❑ Miss ❑ Ms ❑ (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	❑ Allergic reaction to drugs/tapes/creams _____	
❑ High/Low Blood Pressure	❑ Cancer	❑ Skin Disorders
❑ Arthritis	❑ Blood Clots	❑ Depression

❑ Other relevant medical history? (please specify)_____

Recent surgery (< 2 yrs): Yes ❑ No ❑ If 'Yes', please specify_____

Any serious illness: Yes ❑ No ❑ If 'Yes', please specify_____

Are you pregnant? Yes ❑ No ❑

REASON FOR VISIT

❑ low back ❑ neck ❑ knee ❑ shoulder ❑ mid back ❑ hip ❑ ankle
❑ foot ❑ wrist ❑ hand ❑ hamstring ❑ elbow ❑ calf ❑ other _____

REFERRAL SOURCE-How/why did you come to THIS clinic?

❑ Social media: (which?) _____
❑ Google/web browser search: (which?) _____
❑ Website ❑ Yellow Pages
❑ Referred by Health Professional: (who?) _____
❑ Family/friends recommendation: (who?) _____
❑ Live nearby ❑ Signage
❑ Sports Club Affiliation: (which?) _____
❑ Other: (please specify)_____

Would you like to receive a free copy of our quarterly newsletter? ❑ Yes ❑ No

Please turn over and complete whichever section is applicable to you and sign the form

REGISTRATION FORM

WORKSAFE (Injured at work)

Please ensure correct details and Doctors referral is presented. Please request our clinic's WorkSafe 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)

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

Do you have private health insurance? (please tick applicable) Yes ❑ No ❑

If yes, please give name of insurer: _____

Do you have extra cover for Physiotherapy? (please tick applicable) Yes ❑ No ❑

Do you have extra cover for Remedial Massage? (please tick applicable) Yes ❑ No ❑

Name of person responsible for payment of account:

Mr ❑ Mrs ❑ Miss ❑ Ms ❑ Name: _____

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

By signing below,

I agree that the above information is correct, and that **if presenting with a WorkSafe or TAC claim I agree to pay an administration fee of $15.00 per consultation.**

SIGNATURE OF PATIENT _____ **DATE**____/____/____
(or Parent / GUARDIAN if under 16)

NB Our clinic requires 24 hours notice for any cancellation/rescheduling of appointments. Late cancellations or missed appointments will incur a 50% charge of the scheduled fee.