North Road PHYSIOTHERAPY

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

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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.