PLEASE COMPLETE ALL THE INFORMATION REQUESTED ON THIS FORM

Mrs Ms Miss Mr Master Dr

Surname: _____ Given Names: _____

Sex: Male/Female Date of Birth: ___/___/___ Age: ____ Occupation: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Telephone (Preferred): _____ (Other): _____

Email: _____

I consent to receiving electronic communication from this practice Yes ☐

Next of Kin: _____ Relationship to patient:_____ Contact Number: _____

GP Name (if different to referring doctor):_____Suburb: _____

Physiotherapist Name: _____ Suburb: _____

Are you in a Private Health Fund? Yes ☐ No ☐

Do you have a DVA Card? Yes ☐ No ☐

Privacy Consent:

Permission is given to collect and release information on my medical history in order to provide appropriate healthcare. In addition I understand certain information may be used for medical research and audit purposes. A Copy of our privacy policy is available upon request.

Account: **I understand that it is my responsibility to pay my account at the time of my consultation. I undertake to pay any addition expenses incurred in recovering overdue fees.**

Signature: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ / _ _ _ _ / _ _ _ _

Parent/Guardian Consent

If patient is less than 18 years of age

I (Full Name) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ agree to the terms set above.

Guardian Signature: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ / _ _ _ _ / _ _ _ _

Workers Compensation / Third Party

I declare that this is an accepted insurance company claim. I understand if the claim is declined I must pay the consultation cost expected at the time of consult. If at any stage the claim is denied I must pay any outstanding accounts.

Signature: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ / _ _ _ _ / _ _ _ _