Patient Registration

Please check and complete the following details

Title First names Last name

Home phone Work phone DOB

Mobile phone ☐ Opt out of SMS Messaging

If we need to contact you and leave a message, may we use your ☐ Home ☐ Mobile ☐ Work ☐ Email

Email address

Street address

Postal address

Next of kin & Relationship Phone

Address

Treatment area

Family Doctor (Name & address)

Physiotherapist (Name & Address)

Occupation

Private Health Fund Membership number & Ref No

Medicare Ref No Expiry Veterans

☐ Are you making a claim for compensation?

- ☐ Workers' Compensation
- ☐ CTP
- ☐ Personal Injury Claim
- ☐ Public Liability
- ☐ Sports Insurance

Insurer

Date of injury

Claim Number

Address

Phone

Declaration

I have read the Privacy Amendment Act and give permission for correspondence to be sent to my referring doctor, general practitioner, physiotherapist and insurance company where appropriate.

I undertake to pay all fees owing to my Surgeon, including in the event that liability is denied or any outstanding accounts that have not been paid in full by my insurer.

I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery fees and I will also be responsible for any legal costs incurred.

Signed by patient or parent/guardian____ Date _______________________

Name (Please print)____

Please complete the Medical History Form on following page