Suncoast Therapy Connections

Physiotherapy Registration Form

ABOUT YOU

Title: ◯ Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Other

Name: First: | Last: | Known as:

Address:
Suburb and postcode:

Date of Birth: | Occupation:

Home Phone: | Mobile: | SMS reminders: ◯ Y ◯ N

Email:

Emergency Contact: | Relationship to you:

Contact Number:

GP Name:

Medical Centre | Specialist: | Surgeon:

Area of treatment: ◯ Knee ◯ Back ◯ Neck ◯ Shoulder | Other:

Are you of Aboriginal or Torres Strait Islander origin? ◯ Y ◯ N

PAYMENT DETAILS

☐ I am uninsured and will be paying for my treatment privately.

☐ I have Private Health Insurance. ◯ Bupa ◯ Medibank ◯ HCF ◯ AHM Other:

Card Number: Position on Card:

☐ DVA ◯ Gold ◯ White File No:

I sustained an injury and will be making a claim through: ◯ Workcover ◯ Injury net ◯ Insurer ◯ Other

Claim number:
(this includes CTP) Claim Manager:

☐ I have a Chronic Disease Management (CDM) referral from my GP and will be claiming a rebate from Medicare.

◯ NDIS ◯ NDIA Managed ◯ Plan Managed ◯ Self-Managed NDIS no:

HOW DID YOU HEAR ABOUT US?

Referral from Dr (name): Friend/family (name):

☐ Google ☐ Facebook ☐ Website ☐ Word of mouth ☐ Insurance scheme ☐ Other

Other funder: ☐ DVA ☐ NDIS ☐ Workcover ☐ Insurance Claim (CTP) ☐ Other

Would you like to receive occasional letters/promotional flyers ◯ Y ◯ N

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Please discuss any concerns or questions that you may have in relation to the following questions with your Physiotherapist on your first appointment. Thank you for your time and consideration with completing this information to the best of your knowledge.

Have you ever had, or received advice or treatment for any of the following:	Yes	No
Heart condition. This would include previous heart attack, angina, chest pain, rheumatic fever, pacemaker, high cholesterol. *If yes, please describe details:*	◯	◯
◯ **Osteoporosis** ◯ **Osteopenia** (choose one)		
Cancer (tumor, melanoma) *If yes, please provide details:*	◯	◯
Epilepsy, stroke, paralysis, multiple sclerosis, blackouts or fainting attacks. *If yes, please provide details:*	◯	◯
Diabetes, pancreatic, hypoglycaemia or thyroid problems. *If yes, please provide details:*	◯	◯
Depression, anxiety, panic attacks, stress or any mental health condition. *If yes, please provide details:*	◯	◯
Have undergone any **operations, surgery, accidents or injuries** in the past? *If yes, please provide details:*	◯	◯
Are you being treated by your Doctor for **any other condition**? *If yes, please provide details:*	◯	◯
If you are female, are you **currently pregnant** or have you **given birth** in the last 12 months?	◯	◯
Do you have any **allergies**, or have you ever suffered an **allergic reaction**? *If yes, please provide details:*	◯	◯

☐ **INFORMED CONSENT.** I give consent for treatment. I agree to this consent remaining valid until such time as I actively withdraw my consent. I also agree and give consent for my case to be discussed with relevant parties such as medical professionals, third party insurers and/or referrers including Medicare, DVA, NDIS, NDIA, Health Insurers or disease notification as required by law (but not limited to). For use with all Physiotherapists in this practice when consulting with you and for legal disclosure as required by a court of law. You can request a copy of our Privacy Policy at any time and you can also review on our website. www.suncoasttherapyconnections.comm.au

Signature: **Date:**