



# Patient Registration Form

(Please use CAPITAL LETTERS and print clearly, thankyou)

<b>Clinic location</b>	Mingara		
<b>Title (Mr/Mrs/Ms/Dr...)</b>		<input type="checkbox"/> Male	<input type="checkbox"/> Female
<b>Surname</b>			
<b>First name</b>		<b>Partner's name:</b>	
<b>Date of birth</b>	/ /	<b>Children?</b>	
<b>Address</b>			
<b>Suburb / Town</b>		<b>Post Code</b>	
<b>Telephone</b>	<b>Home:</b>	<b>Work:</b>	<b>Mobile:</b>
<b>Main email</b>			
<b>Occupation</b>	<b>Company:</b>		
<b>Medicare number</b>		<b>Number before your name:</b>	<b>Exp date:</b>
<b>Private health fund</b>		<b>Member number:</b>	<b>ID number:</b>

<b>Do you play any sports? (please list):</b>		
<b>Of which sports clubs or gym are you a member?</b>		
<b>Your doctor's details</b>	<b>Name:</b> <b>Phone:</b> <b>Fax:</b>	<b>Address:</b>

### How did you find out about our clinic?

- Doctor:** If other than your usual GP, name and location:
- Therapist:** Physio / Chiro / Osteo / Massage - Name and location:
- Trainer:** Name and location:
- Family / Friend:** Name:
- Yellow pages:**  Internet Yellow Pages  Paper version
- Internet:**  Our website  Association Website (AAESS, APA...)  Search (Google, Yahoo, ...)
- Waiting room material**       **Poster/Advert**       **Brochure/Flyer**
- Saw signage on street**       **Direct Mail**       **Other:**

**Please note:**  
**A 50% cancellation fee is due if less than 24 hours notice is given for cancellation.**  
**Consideration will be given for unavoidable circumstances.**

### Conditions of treatment:

1. As part of a professional physical assessment it may be necessary for your therapist/practitioner to place his or her hands upon you in order achieve the goals of the assessment or treatment. This will be done in a professional manner.
2. You may be expected to remove certain articles of clothing to allow for a detailed musculoskeletal assessment.
3. You are entitled to bring a chaperone if they so wish to.
4. You may ask questions at any stage of the consultation. You are encouraged to communicate to the therapist or practitioner any feelings of discomfort or unease.
5. You may withdraw this consent at any time by stating that you wish to do so.

**Informed Consent:** By signing below you indicate that you have read and understood the above conditions of treatment and agree to these conditions.

**Consent to release/share information:** By signing below you indicate your consent for information (verbal, written, electronic and telephonic) relating to your injury or disease management to be sought from and/or passed on to other health professionals (such as your doctor, specialist or other therapist).

**Patient's signature:** ..... **Date:** .....

*(If filling this form for emailing, don't worry about signing, you can do that when you attend.)*

