women's & men's health PHYSIOTHERAPY

549 Burke Rd, Camberwell 3124
T: 03 8823 8300 | F: 03 8823 8399
E: physio@wmhp.com.au

170 Thomas St, Hampton 3188
T: 03 9521 0444 | F: 03 9521 0777
E: hampton@wmhp.com.au

ABN: 31 108 318 396
www.wmhp.com.au

ADMIN
SURNAME.....
CLIENT #.....

PATIENT REGISTRATION FORM

Have you been to this practice before: YES / NO

Mr Mrs Miss Ms Dr Prof Mx

LAST NAME: ..... **FIRST NAME**: .....

MIDDLE INITIAL: ..... **PREFERRED NAME**: .....

AGE: ..... **DATE OF BIRTH**: / /

ADDRESS: .....

..... **POSTCODE**: .....

PHONE: W: ..... H: ..... Mobile.....

OCCUPATION: .....

EMAIL: .....

Are you happy for us to communicate with you via email (includes Newsletters etc...)? Yes / No

Are you happy for us to leave messages on your home answering machine? Yes / No

Do you consent to us sending you an SMS message to remind you of your appointment? Yes / No

---

Next of Kin: ..... Ph: .....

Relationship of next of kin to you: .....

PERSON RESPONSIBLE FOR ACCOUNT: Self / WorkCover / TAC / DVA / EPC

Do you have Private Health Insurance with "EXTRAS"? Yes / No

If WorkCover or TAC claim, please give details: Claim Number.....

Employer.....

If DVA Gold card, please provide number.....

If EPC, TAC or WorkCover, please note that these will provide for only part of the treatment fee. There will be a gap charge.

Please turn over.....

How did you hear about us?

GP ☐	Urologist ☐	Obstetrician/Gynaecologist ☐	Uro-Gynaecologist ☐
Colorectal ☐	Gastro-Ent ☐	Physio ☐	Family/Friend ☐
Internet ☐	Self ☐	Pilates ☐	M&CH Nurse ☐
Cabrini ☐	Pain Specialist ☐	Sexual Therapist ☐	Other ☐

NAME, ADDRESS & TELEPHONE OF YOUR REFERRING DOCTOR/HEALTH PRACTITIONER:

.....

.....

When a patient is referred to our practice by a General Practitioner (GP), Medical Specialist or other health practitioner, it is beneficial to your care for us to communicate with a written report.

If you were referred to this practice by a GP or Health Practitioner, do you give your consent for a report to be forwarded? Yes / No

NAME, ADDRESS & TELEPHONE OF YOUR REGULAR GP (if not your referring practitioner listed above):

.....

.....

Do you consent to a copy of your report to be sent to your GP? Yes / No

Is there any other health care provider with whom you would like your Physiotherapist to communicate? If so, please list name and address:

.....

.....

Do you consent to your physiotherapist communicating via email with your referring practitioner regarding your care (excluding written report)? Yes / No

Signature: _____ *Date:* _____

Thank you for completing this form. The information you have provided is private and confidential. It will assist your Physiotherapist to work in close liaison with your medical care-givers and to obtain the best outcome for you.

We endeavour to keep on time for our appointments – we appreciate you arriving on time in order for us to achieve this.