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 #……
PHYSIO'S INITIALS……
CONSULT DATE……

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

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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…..

Were you referred by any of the below?

GP ☐ Urologist ☐ Obstetrician/Gynaecologist ☐ Uro-Gynaecologist ☐ Dermatologist ☐

Colorectal ☐ Gastro-Ent ☐ Sexual Therapist ☐ Pain Specialist ☐ Physio ☐

NAME, ADDRESS & TELEPHONE OF YOUR REFERRING PRACTITIONER:

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Do you give your consent for a report to be forwarded to your referring practitioner? Yes / No

If not already indicated above, how did you hear about us?

Family /Friend ☐ Internet ☐ Pilates ☐ Other ☐

Cabrini Health ☐ M&CH Nurse ☐ Midwife ☐

NAME, ADDRESS & TELEPHONE OF YOUR GP OR ANY OTHER HEALTHCARE PROVIDER YOU WOULD LIKE US TO COMMUNICATE WITH (if not your referring practitioner listed above):

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Do you consent to a copy of your report to be sent to the above practitioner? Yes / No

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

*N.B. Please be aware there is a privacy risk associated with email communication. Refer to our Privacy Policy on our website for further information.

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.