Patient Registration Details

□ Mr □ Mrs □ Ms □ Miss □ Master □ Dr

Surname: ______________________________

Given Names: ______________________________

Preferred Name: ______________________________

Address: Number/Street ______________________________

Suburb ______________________________ Post Code__________

Date of Birth: ___/_____/__________

Phone (H): ____________________ Phone (W):____________________

Mobile: ____________________ Email: ____________________

Occupation: ______________________________

Next of Kin: ______________________________

Address: Number/Street:____

Suburb: ______________________________Post Code__________

Phone: ______________________________

General Practitioner: ______________________________ Practice Name: ____________________

Referring Doctor: ______________________________

Private Health Fund: ______________________________ Membership Number: ____________________

Medicare Number: ______________________________ Exp ___/20___ Ref Number __________

Veterans Affairs Number:______________________________Pensioner Number______________________________

Sportreat

PHYSIOTHERAPY I SPORTS MEDICINE I REHABILITATION

ABN 14 081 380 976/002

367 Canning Highway
Palmyra WA 6157

PO Box 491
Melville WA 6956

P 08 9438 2400
F 08 9438 2900

info@sportreat.com.au
www.sportreat.com.au

Medical History

Do you have a cardiac pacemaker or any other devices? □ Yes □ No

Do you have any metal implants? □ Yes □ No

Are you currently pregnant? □ Yes □ No

Do you/have you had any of the following health problems?

Cancer/Tumor	□ Yes	□ No	**Spinal Fractures**	□ Yes	□ No	**Osteoporosis**	□ Yes	□ No
Heart Disease	□ Yes	□ No	**Ross River Virus**	□ Yes	□ No	**Meningitis**	□ Yes	□ No
Arthritis	□ Yes	□ No	**Lung Disease**	□ Yes	□ No	**Diabetes**	□ Yes	□ No
Allergies	□ Yes	□ No	**Chronic Fatigue**	□ Yes	□ No	**Stroke**	□ Yes	□ No

Other ______________________________

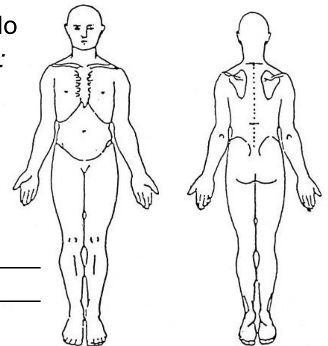
Your Condition

Briefly describe the nature of your condition:

____

Have you received physiotherapy treatment for this problem before? □ Yes □ No

Please highlight your area of concern:



Where did you hear about us?

□ Friend/Relative – Name: ______________________ □ Doctor □ Advert

□ Yellow Pages □ Employer □ Other: ______________________

Account Type

□ Standard

□ Motor Vehicle Claim Number: ____________________ Date of accident: ____/___/____

□ Workers Compensation Claim Number: ________________ Date of accident: ____/___/____

Who is responsible for paying your account?

(Self, parent, solicitor) Full Name: ______________________________

Street Address: ______________________________

Suburb: ______________________________

Postcode: ______________

CANCELLATION POLICY: FAILURE TO GIVE 24 HOURS NOTICE MAY RESULT IN THE FULL CONSULTATION FEE BEING CHARGED.

Sporting Rehabilitation
Physiotherapy
Sport Physician
Sport GP
Massage Therapy
Exercise Physiologist
Wellbeing Screening Medicals
Fitness Appraisal
Post Surgery Rehabilitation

Please see reverse

Please read the following and indicate you understand these with your signature. If you do not understand, please discuss with the secretary before your consultation.

Heat treatment:
When receiving heat treatment, all you should feel is mild comfortable warmth. If you feel any more than this, or if the heat concentrates in any particular spot, you must notify your Physiotherapist immediately, otherwise you may be in danger of being burned.
Electrical Stimulation:
When receiving an electrical stimulation, any concentration of the current, discomfort or pain must be reported immediately to your Physiotherapist. Otherwise you may be in danger of sustaining an abnormal skin reaction. This may result in skin and tissue damage.
Responsibility for accounts:
I accept that consultations are to be paid in full at the time of the visit unless this visit is related to an accepted 3rd part motor vehicle claim, the details of which are provided below. In the event of a 3rd party claim being refused by the relevant authority, I will accept responsibility for payment of any account for professional services given. I understand that any expenses, costs or disbursements incurred by this practice in recovering any outstanding monies will be repaid by myself.

Patient Consent to Collect & Disclose Information
PRIVACY ACT 1988 – Amended March 2014.

The privacy ACT 1988 amended March 2014 ('The Act') requires Health Practitioners to obtain consent from their patients to collect, use and disclose that patient's personal information.

A copy of Sportreat's privacy policy is on display at the reception desk. Upon request, you will be supplied with a copy.

CONSENT

- I acknowledge that I have been given the opportunity to read the Sportreat Information on the Privacy Act 1988.
- I provide my consent for Sportreat Health Care Providers to collect, use and disclose my personal information as outlined in the Sportreat Information on the Privacy Act 1988.
- I understand that I am entitled to access my own health records except where access would be denied as outlined in the Sportreat Information on the Privacy Act 1988.
- I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

AUTHORISATION TO PROVIDE RECORDS/RESULTS

We may need to collect relevant information regarding you from various pathology laboratories, radiology facilities, or from other doctors, specialists, or other health care providers. This authorisation will allow us to collect this information.

I .... of ....

hereby authorize the provision of relevant medical records and/or test/investigation results to Sportreat Health Care Providers, 367 Canning Hwy, Palmyra WA 6157.

SIGNED: .... **WITNESSED:** ....

DATE: ..../........../ 20..........