PATIENT REGISTRATION FORM

Date: ___ /___ /___

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other

Surname: _____ **Given Name/s:** _____

Address: _____

_____ **Postcode:** _____

Email address: _____

Date of Birth: ____ /____ / ____ **Your Occupation:** _____

Phone: Work: _____ Home: _____ Mobile: _____

Emergency Contact: _____

Relationship to you: _____ Phone: _____

GP or Specialist Name: _____

Clinic Name or Address: _____ Phone: _____

Can we confirm your appointments by SMS? ☐ Yes ☐ No

PAYMENT METHOD

☐ **PRIVATE** with ☐ **Private Health Cover**: _____
with ☐ **Concession (HCC / Pension)**: _____ Expiry: _____

☐ **EPC (Medicare)** If yes, Medicare Card No: _____ Ref: __ Expiry: _____

☐ **DVA:** Gold Card ☐ White Card ☐ Number: _____

☐ **WORKERS COMPENSATION:** **Date of Injury / Accident:** ___/___/___
Employer: _____ Phone: _____
Address: _____ Contact person: _____
Insurance Company: _____ **Claim Number:** _____
Case Manager: _____ Phone: _____

☐ **TAC (MOTOR VEHICLE ACCIDENT):**
Claim Number: _____ **Date of Injury / Accident:** ___/___/___

CONSENT FOR SERVICES

I, the undersigned, understand that PhysioFit Berwick Practice requires at least 24 hours' notice should I need to cancel my scheduled appointment and that a cancellation or failure to attend fee may apply.

In addition, in the event where my overdue account is referred to a collection agency and/or law firm, I understand that I am liable for all costs incurred as if the debt is collected in full, including legal demand costs.

X_____ **Patient Signature**