PATIENT REGISTRATION FORM

Please complete both sides of this form and return to reception

MR ARVIND JAIN

PERSONAL DETAILS

Title: *☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Other: _____*

First Name: *_____* ***Preferred Name:*** *_____*

Surname: *_____* ***Date of Birth:*** *_____*

Street Address: *_____*

Postal Address if different: *_____*

Phone: *Home _____ Work _____ Mobile _____*

Email: *_____*

Occupation: *_____*

Medicare: *Card No _____ Ref No _____ Exp _____*

Age Pension No: *_____*

Private Health Insurance: *☐ Yes ☐ No Coverage: ☐ Hospital ☐ Extras ☐ Both*

Fund _____ Membership No _____

Policy Exclusions: *_____*

ACCOUNT DETAILS

Responsible Party: *☐ Self ☐ WorkCover ☐ TAC ☐ DVA*

(If 'Self', proceed to Next of Kin)

DVA: *☐ Gold ☐ White ☐* ***IF WHITE, please indicate:*** *☐ Hip ☐ Knee ☐ Shoulder*

TAC: *Date _____ Claim No _____*

WorkCover: *Date _____ Claim No _____*

Insurance Company _____

Employer _____

NEXT OF KIN

Name _____ *Relationship* _____

Phone _____

REFERRING DOCTOR

Regular GP? ☐ Yes ☐ No

If no, please list the details of your regular GP:

GP Name _____ *Clinic Phone* _____

Clinic Address _____

Do you have a regular physiotherapist? ☐ Yes ☐ No

Physio Name _____ *Clinic Phone*_____

MEDICAL HISTORY

Smoker? ☐ Yes ☐ No

Allergies? ☐ Yes ☐ No If yes: _____

Conditions:

Asthma ☐ Yes ☐ No

Bleeding Tendency ☐ Yes ☐ No

Heart Problems ☐ Yes ☐ No

Rheumatic Fever ☐ Yes ☐ No

Pacemaker ☐ Yes ☐ No

Epilepsy ☐ Yes ☐ No

Kidney Disease ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

High Blood Pressure ☐ Yes ☐ No

DVT / PE ☐ Yes ☐ No

Weight Loss Injections ☐ Yes ☐ No

Current Medications:

Thank you for taking the time to complete this form.