BodyCare
Physiotherapy

Mr / Mrs / Ms / Miss / Mast / Dr

Surname: _____ Given Names: _____

Address: _____ Suburb: _____ Post Code: _____

Date of Birth: _____Occupation: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ Fax No: _____

Email Address: _____

Emergency Contact:_____

Private Health Insurance (Fund Name Only): _____

Pension No : _____DVA No:_____

GP Name :_____

Do you have a pacemaker / metal implant or major Health Problem?
YES / NO If yes, details: _____

_____

_____

Are you currently having radiation therapy (brachytherapy)? YES / NO_____

How did you hear about us? (please circle) WEBSITE DR REFERRAL WALK IN
WORD OF MOUTH OTHER _____

PATIENT TO PLEASE READ THE FOLLOWING:

Heat Treatment: When receiving heat treatment, all you should feel is a mild comfortable warmth. If you feel any more than this you must notify the physiotherapist immediately as there is a possibility you may be burnt.

Electrical Stimulation: When receiving electrical stimulation, any concentration of the current, discomfort or pain must be reported immediately to the physiotherapist. Otherwise there is a possibility of sustaining an abnormal skin reaction or tissue damage.

CONSENT FORM

We require your consent to collect personal information about you. Please read the information and sign where indicated below.

I understand I have the right to request access to my information. I understand that I may withdraw my consent for this practice to use and disclose my personal information, except where legal obligation must be met. I understand that I am not obliged to provide any information requested of me, but my failure to do so will compromise the quality of health care treatment given to me.

Name: _____ Date:_____

Signature : _____Witness: _____

WORKERS COMPENSATIONS CLAIMS ONLY

Employer:_____Date of Injury:_____

Insurance Company: _____Claim No:_____

Case Manager's Name:_____

I _____ hereby authorise Bodycare Physiotherapy to divulge to my employer / insurer / solicitor, any information relevant to my Workers Compensation claim and I confirm that I am aware that should the employer / insurer decline payment that I am irrevocably responsible for payment of the accounts.

Signed: _____ Date: _____ Witness:_____

MOTOR VEHICLE CLAIMS ONLY

Insurer:_____Claim No:_____:

Date of Accident: _____Solicitor:_____

I _____ hereby authorise Bodycare Physiotherapy to divulge to my solicitor / insurer any information relevant to my Motor Vehicle Claim and I confirm that if for any reason the insurer declines payment that I am irrevocably responsible for payment of these accounts.

Signed: _____ Date: _____ Witness:_____