Kilmore Wellness Centre

New Patient Registration Form

Title: _____

First Name: _____ Surname: _____

Preferred first Name: _____

Gender: _____ DOB: _____

Mobile Phone: _____ Home Phone: _____

Email Address: _____

Postal Address: _____

Suburb: _____ Postcode: _____

Do you agree to receive SMS and Email appointment reminders and information YES / NO

Do you have a student card YES /NO Details: _____

Do you have a government concession card YES /NO

Card Details: _____ Expiry Date:_____

Medicare : _____ Ref: ____ Expiry Date: _____

Occupation: _____

Emergency Contact Name: _____ Phone Number: _____

GP Name/ Clinic: _____

Referring Doctor / Surgeon: _____

Do you give us permission to send and receive correspondence to your treating doctors?

YES/ NO

How did you hear about our clinic?

_____

Workcover: Yes/NO Claim Number:_____

DOI: _____Employer Contact:_____

Company Name:_____

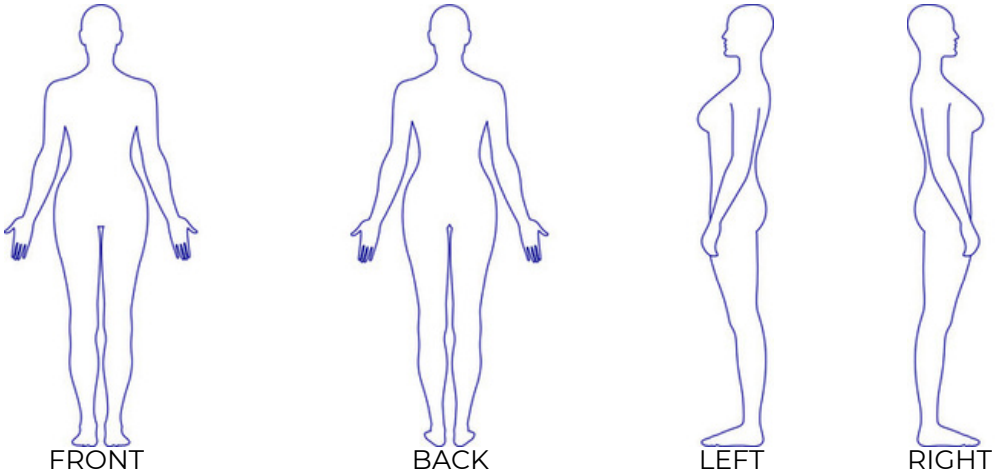
DVA: White/Gold Number:_____ Approved Condition: _____

TAC: DOA:_____ Claim Number:_____

Please note: All Third party account holders must have written approval prior to appointment. Client will remain responsible for account until approval has been provided.

Health and Treatment Information

KILMORE wellness CENTRE



FRONT BACK LEFT RIGHT

Please describe the reason for today's visit (Include any symptoms you may be experiencing) Circle any area of concern on the diagrams.

_____

_____

_____

Have you received any other treatments, scans or tests in relation to this condition? YES / NO

_____

Medical History:

_____

_____

Please Circle if you have any of the following conditions: HEP A HEP B HIV TB

Do you have any allergies?

_____

What would you like to achieve from your treatment today?

_____

Have you previously seen an Allied Health professional? Details

_____

<u>Permission</u>

Do you give consent to the treating practitioner to contact other health professionals involved in the treatment of your condition YES / NO

Do you agree to the practitioner taking photos / video in reference to your medical condition to attach to your medical file as part of your treatment? YES / NO

I agree that the information that I have supplied is true and correct to the best of my knowledge

I understand that cancellation of appointment within 12 hours of appointment time will incur a $50 fee

Signed_____ Date_____