Cassowary Coast
PHYSIOTHERAPY

Title: _________ First Name ____________________________ Known As (if different): _________________________
Last Name: ____ Date of Birth: _______ / ________ / ______________
Home Phone: _______________________________ Mobile Phone: ____
Work Phone: ______________________________ Occupation: ____
Email Address: ____
Physical Address: ____Post code:_______________
Postal Address (if different): ____Post code: ______________

Local Medical Centre: ____________________________________ Local GP: _________________________________
Government Pension Card Number: ________________________________ Type: ____________________________
Private Health Insurance: _______________________________________ Patient ID: ________ Extras Cover: Yes / No

WORKCOVER: No – leave blank Yes – please fill in below & provide a current medical certificate

Claim Number: _________________________________ Date of Injury: _______________________
Case Manager: _________________________________ Phone Number: ______________________
Injured Area: ______________________________ Employer: ________________________________
Work Contact: ____________________________ Phone Number: _________________________

THIRD PARTY: No – leave blank Yes – please fill in below & provide a current medical certificate

Insurance Company: ___________________________________Claim Number: _________________
Case Manager: _________________________________ Phone Number: ______________________
Date of Injury: _________________________Injured Area: ___________________________________
Employer: ________________________________Work Contact: ______________________________
Phone Number: _________________________ Email: ______________________________________

DVA: No – leave blank Yes – please fill in below & provide a current medical certificate

Card Number: ____________________________________ Type: Gold / White: _________________
If White, what areas are covered? ____

MEDICAL: Please tick if you have any of the following

- ☐ Headaches ☐ Epilepsy ☐ Spinal Fractures ☐ Hearing Aids
- ☐ Heart Conditions ☐ Cardiac Pacemaker ☐ Diabetes ☐ Skin Conditions
- ☐ Osteoporosis ☐ Anticoagulant Therapy ☐ Bladder Problems ☐ HRT

Anything else we should know about? ____

NEXT OF KIN: Name: ____________________________________ Relationship: ____________________________
Mobile: ________________________________ Home/Work: __________________________________

Signature: ____ Date: ______ / ______ / __________

Please note: (without prior arrangement) If your treatment is not covered by Workcover or a third-party insurer (must be open & accepted for medical treatment) you will be required to settle the account at the time of consultation.

Tully PHYSIOTHERAPY Mission Beach PHYSIOTHERAPY

our reputation is your reassurance

ABN: 49 618 646 423

T: (07) 4068 2074 E: admin@cassowarycoast.physio W: www.cassowarycoast.physio Postal Address: 1A Webb Street, Tully, QLD, 4854

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Informed Patient Consent

- I hereby acknowledge that all the information I have provided is accurate to the best of my knowledge. If unsure of any information I will inform my practitioner.
- I understand that I may require medical clearance from my general practitioner to determine my suitability to commencing a regular exercise program.
- As a patient it is my responsibility to notify my practitioner if there are any changes to my medical condition including changes in medication.
- I give permission for my practitioner to contact my general practitioner or other allied health professionals to obtain any relevant information regarding my condition.
- I understand that engaging in regular physical activity can cause potential risk of injury or bodily harm and I will not hold the practitioner liable if this occurs

Privacy Policy

- We are committed to ensuring that all personal information that is disclosed in consultations and sessions will remain confidential and only be accessible by appropriate staff. All personal information is stored in a secure location protected from unauthorised access, modification or disclosure. All staff are regularly reminded of the importance of this matter and any breach in privacy is not tolerated.

Consent to Treatment

- I have read and understand the above information and give my consent to treatment. I agree to this consent remaining valid until such time as I withdraw my consent. I also agree and give consent for my case to be discussed with AMS practitioners, treating doctor and 3rd party bodies if appropriate.

Patient Name (printed): ____

Signature: ____ Date: ______ / ______ / __________
Parent or Guardian to sign if patient is under 18 years of age

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