Cassowary Coast
REHABILITATION+ PILATES
Tully · Mission Beach

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.

our reputation is your reassurance

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