Patient Registration

Title _____ First name __________________________ Middle Initial ____ Surname ________________________

Date of Birth ____________________ Home phone ________________________ Mobile phone _________________

Street address, including postcode ____

Email address ____

Occupation ____________________________________

Parent's name if under 18 years old ______________________________ Parent's Mobile ______________________

Treatment Area

☑please tick

☐ Left ☐ Right ☐ Shoulder ☐ Elbow ☐ Clavicle

Entitlements

Medicare Card No: | | | | | | | | | | **Medicare ID No: (Left of Name)** | | **Expiry Date:** __/__

For claiming purposes, if patient is under 12, parent's name, DOB and Medicare Number (including reference no):

Name: _________________________________ DOB: ________________ Medicare Number if different _______________________

Veteran's Affairs: **DVA Number:** | | | | | | | | |

Private Health Fund Details

☑please tick

☐ **Private Health Fund Name of Fund** _______________________ **Fund No:** ______________________________

☐ **NO Private Health Insurance (self-funded)**

General Practitioner

These details allow us to keep your family doctor informed of your treatment.

☐ **I do not have a family doctor/General Practitioner**

Name____**Phone**_________________________________

Address____

Physiotherapist

These details allow us to keep your physiotherapist informed of your treatment.

Name____**Phone**_________________________________

Address____

Are you making a claim for compensation?

☐ **NO**

☑please tick

☐ **Workers' Compensation** ☐ **CTP** ☐ **Personal Injury Claim** ☐ **Public Liability**

Claim Number___________________________________ **Date of Injury**_________________________

Insurance Company Name:____

Address ____

Declaration

I have read the Privacy Amendment Act provided and give permission for correspondence to be sent to my referring Doctor and General Practitioner and Insurance Company where appropriate.

I undertake to pay all fees owing to Dr Duckworth, including in the event that liability is denied or any outstanding accounts that have not been paid in full by my insurer.

I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery fees and I will also be responsible for any legal costs incurred.

Signed by patient or parent/guardian ____ **Date** _________________

Name (please print)____

Please complete Medical History Form on following page