NEW CLIENT DETAILS

Synergy Health Physiotherapy & Pilates

TITLE (PLEASE CIRCLE)	MR | MRS | MS | MISS | DR | PROF				
SURNAME		GIVEN NAME/S		DATE OF BIRTH	/ /
ADDRESS		SUBURB		POSTCODE	
HOME		WORK		MOBILE	
EMAIL ADDRESS					
PREFERRED METHOD OF CONTACT (PLEASE CIRCLE)	HOME | MOBILE | WORK | EMAIL				
CURRENT OCCUPATION		EMPLOYER			
DOCTOR		ADDRESS		PHONE	
PERSON TO CONTACT IN CASE OF AN EMERGENCY				PHONE	

Referral Details – How did you find us?

REFERRED BY (PLEASE CIRCLE)	DOCTOR | HOSPITAL | FAMILY | FRIEND | YELLOW PAGES | GOOGLE | HEALTH FUND		
OTHER		EMPLOYER	

Account Details

DO YOU HAVE PRIVATE HEALTH INSURANCE? (PLEASE CIRCLE)	YES | NO		
HEALTH FUND		MEMBERSHIP NO.	
WILL YOU BE CLAIMING WORK COVER?	YES | NO	CLAIM NO.	
WILL YOU BE CLAIMING VETERAN AFFAIRS/EPC?	YES | NO	DVA/MEDICARE NO.	

General Health Questions

DO YOU HAVE ANY OF THE FOLLOWING? (PLEASE CIRCLE)			
DIABETES	YES | NO	ARE YOU PREGNANT?	YES | NO
HEART CONDITION	YES | NO	HIGH / LOW BLOOD PRESSURE	YES | NO
PACEMAKER	YES | NO	OSTEOPOROSIS	YES | NO
METAL IMPLANT	YES | NO	ARTHRITIS	YES | NO
INFECTIOUS DISEASES	YES | NO	ALLERGIES	YES | NO
PRESENT MEDICATIONS TAKEN			
DATE OF INJURY/CONDITION (IF APPLICABLE)			
CONCERNS ABOUT YOUR CONDITION			

PRIVACY: The information provided to us remains private and confidential in accordance with the Privacy Policy of Synergy Health Group

Please read and sign the following statement

I certify that the above information is true and correct.

I understand that payment is required at time of consultation. I understand that I may incur a cancellation fee if I cancel within 24 hours of my booked appointment.

I declare that if a claim is unsuccessful through workers compensation or CTP, that I accept full responsibility for payment of the account.

I do / do not consent to receiving information, special offers or newsletters from Synergy Health Group from time-to-time.

SIGNATURE		DATE	