Absolute Hydrotherapy - **Patient Registration Form**			
Surname			
First Name			
Date of Birth			
Mobile Phone		Home Phone	
Email			
Postal Address			
Suburb		Post Code	
Occupation			
Medicare Number		Ref No.	Expiry
Concession card Pension card No.			
GP / Local doctor			
GP clinic / address			
Surgeon / Specialist (if applicable)			
Land Physiotherapist			
Current Medication			
Emergency contact person	Name		
	Mobile phone		
	Relationship to patient		
Referral source			
Do you identify as Aboriginal or Torres Strait Islander ?		**YES / NO**	

ACCOUNT DETAILS			
o **Private Health Insurance details**	Health fund		
	Member number		
	Patient number		
	Card issue date		
o **DVA**	Veteran number		
	TPI	GOLD	White
	Referral	**YES / NO**	
o **Work cover claim**	Date of injury		
	Claim number		
	Employer name		
	Employer address		
	Employer contact person & telephone		
	Insurance agent		
	Case manager name		
	Case Manager telephone and email		
o **TAC**	Date of accident		
	TAC Claim number		
o **Medicare**	EPC referral	**YES / NO**	
o **NDIS**	NDIS number		
	Invoicing details		

Do you have a medical history with any of the following:		
	YES	**NO**
Epilepsy		
Headaches		
Blood pressure HIGH / LOW		
Heart condition		
Recent stroke		
Peripheral vascular disease		
Respiratory disease		
Incontinence of Urine / Bowel		
Open wound		
Skin condition		
Ear infections		
Hearing impairment		
Eye infections		
Visual impairment		
Tinea / Warts on feet		
Fever		
Acute Inflammatory Disease		
Infectious diseases		
Pregnancy		
Swallowing problems		
Radiotherapy		
Kidney problems		
Do you have a fear of water?		
Can you swim?		

Terms	The patient will accept full liability for WorkSafe, TAC, Medicare and DVA claims which are rejected
	I have read and agree to comply with the COVID Safe rules and the Hydrotherapy patient instructions
	Absolute Hydrotherapy keeps electronic records and will ensure that your details are private and confidential. I consent to the Absolute Hydrotherapy privacy policy
	I consent to receive Hydrotherapy and Physiotherapy
Signature	
Print Name	
Date	
By signing this form, you accept all the terms and conditions	