O-health

NEW PATIENT REGISTRATION FORM

Title: Mr / Mrs / Miss / Ms Gender: Male ☐ Female ☐

First name: _____ Surname: _____

Preferred name: _____

Date of Birth: _____/_____/_____

Mobile no. _____ Home no. _____ Work no. _____

Street address: _____

City: _____ Postcode: _____

Email address: _____

Emergency contact: _____ Relationship: _____

Emergency contact number: _____

Your doctor's name: _____

Doctor's Company Name: _____

Medicare number: _____

Reference number: _____

1. Consent given to contact GP if necessary. Yes ☐ No ☐

2. How did you find out about our practice?

☐ Facebook ☐ Instagram ☐ Yellow Pages Online

☐ Directory Assist ☐ Our Website ☐ From my Doctor ☐ Google

☐ Brochure/ Flyer ☐ Friend Referral (full name): _____

3. In which part of the body is your injury or pain located (if any)?

_____

OFFICE POLICY

Our goal is to deliver an exceptionally friendly and prompt, professional service providing you with best practice health care. We strive to address the issues that you have brought to the clinic and treat the **cause** of your condition, not just the symptoms or find temporary solutions. Our experience tells us that there are some key areas we need to focus on to ensure that you receive the greatest benefit from our services.

Recovery: Remember that healing and recovery takes time and not everyone heals/recovers at the same rate. If at any time during your care, you do not feel that you are responding as well as expected we would ask that you discuss this with your therapist. We want you to get the most from your care at O-health.

Excellence in healthcare: We are continually upskilling and updating our health care practices to provide you with the latest knowledge and techniques. To achieve this we travel periodically to conferences and seminars. We may need to book your appointments around those times or else provide another highly qualified therapist to continue your care.

Fees and Your Account: Fees for private patients are due at the time of service. HICAPS and EFTPOS facilities are available at the front desk for automatic claiming through your private health fund. Workcover, TAC, MAA and DVA patient accounts will be sent directly to the appropriate body.

Appointment Scheduling: Your therapist will outline a recommended action plan as the best plan for your injury. You will achieve the maximum results when you keep your recommended action plan to this schedule. Therefore, to receive the most out of your care and to save time we ask that you schedule your appointments in advance.

Missed Appointments: Missed appointments will slow your recovery. We ask that wherever possible you keep all your appointments. Our practitioner's recommend a course of action so that we have the fastest and most effective resolution of your symptoms possible. If an appointment must be changed, 24 hours notice is appreciated. If less than 8 hours notice is given for a cancellation, a cancellation fee of $50 may be charged. Consideration will be given for unavoidable circumstances and if you reschedule. This fee is not covered by compensable bodies and must be paid by the patient. People who repeatedly miss or reschedule appointments will regretfully be discharged from care as we realise you will not reach your health goals.

Keeping in touch: From time to time we want to send you information around your health, wellbeing and information relevant to your care. This may take the form of emails, clinic newsletters or phone calls.

Please tick this box so we can continue to offer you exceptional care and communication ☐

I have read and fully understand the above Office Policy Form

Name: _____

Signed:_____ Date: / /

O-health

CONFIDENTIAL
PATIENT CASE HISTORY

List any medications you are taking

_____

_____

Have you ever taken oral cortisone or prednisone (including asthma medications such as pulmicort, symbicort, flixotide & seretide)? Yes / No

Are you pregnant? Yes / No

Do you have or have you ever had?: (please tick)

- □ High blood pressure
- □ Heart attack
- □ Heart problems
- □ Strokes
- □ Diabetes
- □ A pacemaker
- □ An aneurysm
- □ Asthma/Respiratory
- □ Cancer
- □ Osteoporosis
- □ Rheumatoid arthritis
- □ Ankylosing spondylitis
- □ Psoriatic arthritis
- □ Reiter's arthritis
- □ Spinal trauma
- □ Spinal fracture
- □ Spinal surgery
- □ Dislocations
- □ Ligament injuries
- □ Cartilage injuries
- □ Osteoarthritis
- □ Dizziness

Have you seen another therapist for this injury before? Yes / No

If YES, who? (please circle) GP Surgeon Chiropractor

Other (what type of therapist)?_____

Patient's Signature: _____

Date:_____

"Thank you for the time taken to complete this form."