PATIENT INFORMATION ONLINE SCREENING FORM

nq physio SOLUTIONS

PERSONAL DETAILS:

FIRST NAME:		LAST NAME:
ADDRESS:		SUBURB:
PHONE (HOME):	PHONE (WORK):	DOB:
MOBILE:	EMAIL:	
PREFERRED PHONE CONTACT (CIRCLE ONE) HOME / WORK / MOBILE		PREFERRED REMINDER (CIRCLE ONE) EMAIL / SMS / PHONE
PRIVATE INSURER:		OCCUPATION:

HOW DID YOU HEAR ABOUT US?				
CORPORATE FLYER	FACEBOOK	FLYER	NEWSPAPER	REFERRAL
SIGNAGE	WEB SEARCH/WEBSITE	WORD OF MOUTH	YELLOW PAGES	EMAIL

THIRD PARTY INFORMATION:

DVA: TPI / GOLD / WHITE	DVA FILE #:	REFERRED BY:

INSURER:	CLAIM #:	REFERRED BY:

WORKCOVER:	CLAIM #:	REFERRED BY:
CASE MANAGER:	MEDICAL CERTIFICATE DATES:	

CHRONIC MANAGEMENT PLAN:	MEDICARE #: _ _ _ _ _ _ _ _ _ _ / _	REFERRED BY:

PAYMENT DETAILS FOR PREPAYMENT OF $45 TELEHEALTH PHYSIOTHERAPY SESSIONS

CREDIT CARD NAME:	CVV:
CREDIT CARD NUMBER:	EXPIRY DATE:

REASON FOR APPOINTMENT:

CURRENT INJURY/CONDITION:
CURRENT MEDICAL CONDITIONS:
CURRENT MEDICATIONS:

PLEASE CIRCLE IF ANY OF THE FOLLOWING APPLY (current or history of):					
PACEMAKER	ARTIFICAL IMPLANT	JOINT REPLACEMENT	HEART CONDITIONS	DIABETES	EPILEPSY
OSTEOPOROSIS	INFLAMMATORY ARTHRITIS	CANCER OR MALIGNANCY	HEP A, B OR C HIV +VE	BLOOD DISORDERS	ANTICOGULANT MEDICATIONS
CORTICOSTEROID MEDICATIONS	HISTORY OF FAINTING	ANY AREAS OF NUMBNESS	CURRENT INFECTIONS	PREGNANT	REACTION TO TAPE
IF YES PLEASE PROVIDE ANY RELEVANT INFORMATION:					

I, ……., hereby certify that the above information is correct. I undertake to pay all medical fees incurred in the event that my third party insurer fails to do so. I understand that if referred for treatment by a GP, specialist, other health professional or third party insurer, my referrer will be kept up-to-date with my progress. I authorise the release of any medical information required for my treatment from my GP, specialist, other health professional or third party insurer involved in my management. I agree for the above credit card to be used to prepay my online Telehealth Physiotherapy sessions.

Signed …… Date ……