|  |
| --- |
| PERSONAL DETAILS FORM “TELEHEALTH”THE PHYSIO LAB |
| **First Name:** | **Surname:**  |
| **DOB:** |  |
| Preferred Pronoun: |
| Street Address: |  |
| Suburb: | Postcode: |
| **Mobile:** | **Email:** |
| Phone: |
| Occupation: |
| How did you find us? Friend (name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor /Website/Flyer/Other \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Referring Doctor (GP/Specialist) Name: Phone: |
| **Workers Comp/CTP (please fill in claim information if applicable - prior approval required)** |
| WC  | CTP | Date of Injury: |
| Insurance Company: | Claim Number: |
| Case Manager: | Phone: |
| **HEALTH** |
| Surgeries: |
| Medications:  |
| Area of Injury: |
| Sport and Exercise: |
| Please **BOLD** if you have/had any of the following: |
| Pregnant | Epilepsy | Arthritis | Cancer |
| Bleeding disorders | Pins and Needles | Blood Pressure | Asthma |
| Osteoporosis | Dizziness | Diabetes | Heart Disease |
| Other medical conditions/allergies: |
| **PLEASE ACKNOWLEDGE YOU HAVE READ THE FOLLOWING BY PLACING AN “X” NEXT TO THE BOX** All your information and records are confidential and will not be provided to a third party without your consentWe use Zoom for Telehealth conferencing. They do not have access to identifiable health information, Zoomprotects and encrypts all audio, video and screen sharing data. Assessment and treatment may require a level of undressingPayment is expected prior to your appointment. **24 hours notice** is required for cancellations. This allows us to accommodate patients on the waiting list. A **fee of $60 will be charged** for broken appointments.  |
| **PLEASE INFORM YOUR PHYSIO IF YOU DO NOT CONSENT TO ANY OF THE ABOVE** |
| **PRINT NAME:**  | **DATE:** |