LEAP HEALTH
Physiotherapy | Podiatry | Exercise Physiology | Dietetics

Full name: Pronouns:

Mobile: Home / Work: Date of birth:

Address:

Email: Medicare #: IRN:

Next of Kin: Name & contact: Relationship:

- What is your patient status (please circle):

Private **Work cover** **Veteran affairs** **MAIB** **EPC** **NDIS**

- How did you hear about Leap Health (please circle)?

Family/Friend **GP** **Other:**

☐ I consent to Leap Health contacting my referrer for the purpose of saying thank you. Please provide name and contact details :

Regular GP and Medical Practice:

Current medications:

Please check any of the following medical or skin condition

☐ Recent surgery	☐ Blood pressure High/Low	☐ Lung/breathing problems
☐ Smoker	☐ Heart condition	☐ Diabetes (type 1/2)
☐ Pregnant	☐ Tumours/Cancer	☐ Thyroid problems
☐ Given birth recently	☐ Dizziness/fainting	☐ Cholesterol problems
☐ Epilepsy	☐ Arthritis (Rheumatoid/Osteo)	☐ Metal implants

Are you allergic to any of the following:

☐ Latex	☐ Silver Nitrate	☐ Tapes (Zinc Oxide)
☐ Iodine	☐ Nuts - Please inform reception	

In accordance with Federal Government Privacy Legislation of December 21 2001, this Practice has a Privacy Policy on handling patient information. The practice collects information from you for the primary purpose of providing quality health care and aims to ensure that any information we hold is accurate, complete and up-to-date. We require you to provide us with your personal details and medical information so we may properly assess and treat you. The information you provide may also be used for administrative and billing purposes and for communication with your General Practitioner and/or Referrer associated with your treatment. You are entitled to withhold certain information and you have a right to access the information collected about you, except in certain circumstances where access might legitimately be withheld. Your consent is required to the handling of your personal information by the practice. Please sign below to indicate your consent.
Declaration: I acknowledge my account will need to be paid on the day of attendance, unless my account is covered under a third party. In such cases, I will provide all relevant information to Leap Health to bill a third party and hereby concede that I am liable for the account should the account not be settled in full. I acknowledge that if I fail to give 24 hours notice to cancel an appointment, I will be charged a cancellation fee. I hereby grant permission for Leap Health to access all images and reports relating to my condition. I have read, fully understood, and completed the above screening. To the best of my knowledge, the information I have is true and correct.

Sign: Date: / /

Is the patient a minor (under 18)? Yes ☐ No ☐ – If Yes: Guardian Name: Signed on behalf of :