LEAP HEALTH

Physiotherapy | Podiatry | Exercise Physiology | Dietetics

ABN: 89 131 395 983 www.leaphealth.com.au

New Patient Information

Name: _____ DOB: _____

PH: (H) _____ (M) _____ (W) _____

Address: _____ Post code: _____

_____ _____

Email*: _____

Next of Kin: _____

What is your patient status? (please circle)

Private Work cover Veteran affairs MAIB EPC

How did you hear about Leap Health?

_____

Regular GP & Medical Practice? _____

Please list any medications you are currently using:

_____

_____

_____

Please circle below if applicable to you:

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

Are you allergic to any of the following?

Latex
Silver Nitrate
Tapes (Zinc Oxide)
Iodine
Other (Please specify below)

If you answered yes to any of the above, please provide further details here:

_____

_____

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. Your additional consent will be obtained should the information be required for any other purpose (eg legal reports, research). 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 Workers Compensation, MAIB or DVA. In such cases, I will need to provide all relevant information to Leap Health to bill a third party. 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 screen. To the best of my knowledge, the information I have provided is true and correct.

Sign: _____ Date: ____/____/____