Peter Melvin Dip Phty., Dip.M.T Assoc.Hand Therapist
Principal Physiotherapist

Patient Registration Form

Ph 426 6619 / 021 031 7287
silverdale@coastphysio.co.nz

SECTION 1 - PERSONAL INFORMATION (Please complete all sections)		
FIRST NAME:	**LAST NAME:**	
ADDRESS:	**DATE OF BIRTH:** ☐ **MALE** ☐ **FEMALE**	
	ETHNICITY:	
MOBILE:	**HOME PHONE:**	
PARENT NAME & CONTACT DETAILS:		
E-MAIL ADDRESS: **(Parent/Caregiver)**	Email address will only be used for sending of exercise programs and initial report	
DOCTOR:		

SECTION 2 - GENERAL HEALTH QUESTIONNAIRE:		
☐ Allergy (Specify) ☐ Recent Concussion	☐ Heart condition ☐ Epilepsy	☐ Asthma/Respiratory/Hyperventilation Relevant medication:

DATE OF INJURY:	**TIME OF INJURY: (approx)**	**SPORT?**
SCENE: e.g. Home, Work, Sport, School, Vehicle	**LOCATION:** e.g. Tauranga, Auckland	

CAUSE OF INJURY: Describe what you were doing and where your injury is:
e.g. Lifting carton from car and hurt lower back

Number if Claim Already Registered: Please advise if you need us to call ACC for the details.	☐ ACC- New	Office use only: Claim No: Read Codes:

SECTION 4 - CONSENTS

I hereby agree to consent to treatment by a Physiotherapist for the purpose of providing comprehensive physiotherapy services as may be necessary in support of my illness, injury or condition. I have been given the opportunity to read clinic information prior to treatment. I understand I have the right to decline part or all of the treatment being offered. I understand my right to a second opinion and chaperone.

AGREEMENT TO PAY:

I understand that I am liable to pay for :

- $10 per visit
- Any treatment that is declined by ACC
- The costs of materials such as collars, splints, tape etc
- If I fail to attend or cancel my appointment within 4 hours I will be required to pay a non attendance fee ($10)
- We require payment on the day unless by prior arrangement.

ACC DECLARATION

I DECLARE: That the information I have given about this claim is true and correct and that I have not withheld any information likely to affect my application.
I AUTHORISE: (1) The collection and release of any information about me to the extent that this is needed to prevent future injuries, determine cover and/or assess my entitlement to compensation, rehabilitation assistance, medical treatment and/or the appropriate level of care and personal attention that I should receive. (2) ACC to contact anyone who holds relevant information, including any external agencies or service providers (such as medical practitioners, specialists, New Zealand Police, and Treatment Providers, IRD, WINZ, Assessment Agencies, employers and witnesses to the injury

SIGNED: *(If under 16 must be signed by parent/guardian)*	**DATE:**

ACC PROVIDER NO : 16CDMK	**PROVIDER SIGNATURE:**	**DATE:**

SILVERDALE
7 Polarity Rise
426 6619

OREWA
174 Centreway Road
426 1945

MANLY
53C Rawhiti Road
424 1309