SPORTSFIT
physio & health

PATIENT REGISTRATION FORM

PATIENT INFORMATION			
First Name: Surname:			Title: ☐ Mr ☐ Miss ☐ Ms ☐ Mrs ☐ Dr ☐ Other:
Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them			
Address:	Suburb:	Post Code:	
DOB:	Contact Numbers Home: Mobile: Work:	Occupation:	
Email: @			
Private Health Insurance: ☐ Yes ☐ No	If Yes, Name of fund:		
Name of GP: Dr	Contact No (if known):	Consent to liaise with your treating health professionals? ☐ Yes ☐ No	
Address of GP (if known):			

EMERGENCY CONTACT	
First Name: Surname:	
Contact No:	Relationship:

REFERRING DETAILS	
How did you hear about SportsFit? ☐ Referred ☐ Online/Website ☐ Passing by ☐ Brochure ☐ Sporting Club ☐ Other:	
Name of Referrer (Person/Sporting Club):	Contact No (if known):

I give consent for my practitioner to contact me via email (this may include exercise prescription, follow-up advice): ☐ Yes ☐ No

Please note: We require greater than 24 hours' notice of cancellation or a fee may be incurred.

I declare the above information is true and to the best of my knowledge.

Signed: _____

Patient / Guardian Date:

By signing this form, you will be automatically subscribed to our mailing list. You may unsubscribe at any time.