NEW PATIENT - REGISTRATION FORM

PATIENT DETAILS

◯ Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Dr ◯ Other:

First Name:	Surname:	Date of Birth:
Address:		
Email:	Phone Number:	
Primary Language:	Do you need an interpreter? ◯ Yes ◯ No	
Emergency Contact / Next of Kin Name:		
Contact Number:	Relationship to you:	

MEDICARE

Medicare Card Number:	
Reference Number:	Expiry Date:

HEALTH FUND / WORKCOVER / DVA / CTP

Please select all that apply:

☐ **Private Health Insurance**	Health Fund Name:	
	Member/Policy Number:	
☐ **DVA**	Card Number:	
	◯ Gold ◯ White ◯ Orange	
☐ **CTP**	Claim Number:	Accident Date:
	Insurer Name:	
☐ **WorkCover**	*Please fill in details on the following page	
☐ **Pension or Healthcare Concession Card**	Card Number:	

GP DETAILS

GP Name:	GP Contact Number:
Practice Address:	

REFERRER

◯ Referred by GP ◯ Referred by Other (Please fill in details below)

Referrer Name:	Referrer Contact Number:
Referrer Practice Address:	

NEW PATIENT – WORKCOVER DETAILS

Full Name:	**Claim Number:**
Date of Injury:	**Approximate time of injury:**
Employer Name:	**Job Title:**
Employer Address:	
Insurer Name:	**Insurer Contact:**
Case Worker:	
Contact Number:	**Contact Email:**

Please give a detailed description of the incident and injury.

1. What happened?

2. Describe the injury you sustained.

3. Where did it occur?

4. Did this occur during your normal work duties? ◯ YES ◯ NO – If no, please explain below.

5. Any additional details:

NEW PATIENT – MEDICAL HISTORY

REASON FOR REVIEW		
◯ Brain	◯ Spine (see below) ***Please fill in a pain diagram**	◯ Other - please specify:

SPINE PATIENTS			
Have you trialled:	☐ Physiotherapy	If so, did it help? ◯ Yes ◯ A little ◯ No ◯ Unsure	
	☐ Spinal injections	If so, did it help? ◯ Yes ◯ A little ◯ No ◯ Unsure	
	☐ Pain medications	If so, did it help? ◯ Yes ◯ A little ◯ No ◯ Unsure	

PAST MEDICAL HISTORY		
Please tick all that apply:		
☐ Heart Disease / Heart Attack	☐ Stroke	☐ DVT or Pulmonary Embolism
☐ Type I or ☐ Type 2 Diabetes	☐ Peripheral Vascular Disease	☐ Bleeding Disorder
☐ Lung Disease	☐ Kidney Disease	☐ Cancer
Please list any other medical diagnoses:		
☐ Previous brain or spine surgery? Please list procedures and dates:		

MEDICATIONS		
Please tick if you are on any of the following blood-thinning medications:		
☐ Aspirin	☐ Clopidogrel (Plavix)	☐ Warfarin (Coumadin/Marevan)
☐ Apixaban (Eliquis)	☐ Dabigatran (Pradaxa)	☐ Rivaroxaban (Xarelto)
☐ Other blood thinner - please specify:		
Please list any other medications (pain relief, diabetic medications etc.):		

ALLERGIES			
Do you have an allergy to any of the following?	☐ Penicillin	☐ Iodine	☐ Latex
Please list any other allergies:			

SOCIAL / FUNCTIONAL HISTORY		
◯ Right-handed or ◯ Left-handed	Height (cm):	Weight (kg):
What is your current occupation?		
Do you smoke? ◯ No ◯ Ex-smoker ◯ Yes (cigarettes/day for years)		
Do you drink alcohol? ◯ No ◯ Yes (average standard drinks/week)		
Do you use any recreational drugs? ◯ No ◯ Yes		
Do you require assistance with daily activities? ◯ No ◯ Yes - please specify:		

NEW PATIENT – CONSENT FORM

Patient Name:

Date of Birth:

By signing below, I acknowledge and agree to the following:

1. **Consent to Consultation and Treatment:**
   I consent to consultations, examinations, diagnostic tests, and non-surgical treatments provided by Dr. Dower and clinical staff. I understand that any surgical procedures will require a separate informed consent process.
2. **Privacy and Confidentiality:**
   I understand that my personal and health information is collected and stored securely to support my medical care. My information will be handled in accordance with privacy laws, and I may request access to or correction of my records at any time.
3. **Sharing of Health Information**
   I understand that relevant information may be shared with my GP, referring doctor, other specialists, and third parties such as Medicare, health funds, insurers or WorkCover where necessary for my treatment or as required by law. I may withdraw this consent in writing at any time.
4. **Financial Responsibility:**
   I accept responsibility for payment of fees for services provided. I understand that private billing may apply and that I must notify the practice promptly of any changes to my insurance.
5. **Cancellation and No-Show Policy:**
   I acknowledge that cancellations made less than 24 hours before the appointment, or failure to attend (no-show), will incur a $100 cancellation fee.

Signature:

Name:

Relationship (if signed on behalf of patient):

Date: