Dr. Timothy Wood

Sport and Exercise Medicine

Patient Registration Form

TITLE: MR / MRS / MS / MISS / DR (please circle/underline) DATE OF BIRTH: ____ / ____ / ____

SURNAME: _____ GIVEN NAMES: _____

ADDRESS: _____

SUBURB: _____ POSTCODE: _____

TELEPHONE: Home: _____ Work: _____ Mobile: _____

EMAIL ADDRESS: _____

MEDICARE NO: _____ IRN: _____ (Individual reference number) EXPIRY DATE: ____ / ____

PRIVATE INSURANCE: _____ MEMBER NUMBER: _____

COVER TYPE: Hospital ☐ Extras ☐ Have you been a member for over 12 months? Yes ☐ No ☐

Health Care Card ☐ Pension Card ☐ Department of Veterans Affairs ☐

CARD NUMBER: _____ EXPIRY DATE: ____ / ____

PERSON RESPONSIBLE FOR PAYMENT:

SELF ☐ PARENT ☐ VETERANS AFFAIRS ☐ OTHER: _____

REFERRAL DETAILS

DOCTOR: _____

ADDRESS: _____

PHYSIOTHERAPIST/CHIROPRACTOR etc. : _____

ADDRESS: _____

MEDICAL HISTORY

Do you have any allergies? Yes ☐ No ☐ If yes please detail: _____

Do you smoke? Yes ☐ No ☐ If yes how many a day? : _____

Do you take any prescription medications? If so, please list : _____

_____

Do you take any nutritional or health supplements e.g. glucosamine and/or fish oil? If so, please list: _____

_____

SIGNATURE: _____
