MELBOURNEARTHRITIS
COMPREHENSIVE APPROACH TO ARTHRITIS

MELBOURNE ARTHRITIS PATIENT REGISTRATION

Personal Information:

Title:_____ Surname:_____First Name:_____

Date of Birth:__ / __ / _____ Phone:_____Mobile:_____

Address:_____

E-Mail: _____

Next of Kin Contact name:_____ Phone:_____

Financial Information

Medicare #:_____ Ref # _____ Exp:_____

Private Health Fund:_____ Membership # : _____

Extras: Yes / No

DVA: Gold / White Number:_____

Referring Doctor

Doctors Name:_____

Address:_____

Medical History

Autoimmune disease	Bruise easily	Cancer
Lupus	Blood clot/ Emboli	Depression
Rheumatoid arthritis	Osteoarthritis	Asthma/COPD
Multiple Sclerosis	Osteoporosis(low density)	Diabetes
Fibromyalgia	Knee replacement	Allergy
Chronic fatigue syndrome	Hip replacement	Stroke
Migraine	Shoulder replacement	Seizures/Faint
Heart problem	Arthroscopy	Anxiety
High /Low blood pressure	Disc herniation	Balance deficiency/Fall
Pacemaker	HIV	Other:
Canal stenosis	Hepatitis B / C	

1-Authority for us to choose and alter the treatment. Please read and tick the boxes if agree:

I authorise my therapist to choose and change my treatment during the course of treatment in Melbourne Arthritis after discussing with me. Following the assessment, different types of treatments may be suggested by the therapist to optimize the result of the treatment. This includes using Low-level laser therapy, Electro Shockwave therapy, Dry needling, Ultrasound, Emsella, EMSCULPT or other equipment, which will be explained and discussed prior to use of them.

2- Authority for us to provide your information to necessary health care providers.

I authorise Melbourne Arthritis to provide my information about my personal care to other health care providers for the purpose of optimising my health care management. Melbourne Arthritis will maintain ownership of this information and will release only such information as is deemed for care provision.

3- Authority to release personal information to us.

I authorise Melbourne Arthritis to obtain and access all of my medical and other information required for my care. I consent to the release of medical, clinical or other information by any medical practitioner, hospital, and clinic, insurance company, Centrelink, the Department of Defence or other organisation appear to be relevant.

I understand that by signing this form it will mean that Melbourne Arthritis and delegates will be able to ask any person who holds information about you to disclose that information, if that information seems relevant to providing my medical care.

In general, this form will be used to access your medical records in the possession of other Practitioners and Hospitals.

4- Authority to receive sms and email from Melbourne arthritis

This authorises Melbourne Arthritis to send you SMS reminder and new treatment option information if required.

A signature from one of the parents or authorized person is required for treating of a minor(the patient under 18 years old age).

I consent to Melbourne Arthritis practitioners to perform treatment upon myself.

Patient Name:_____

Signature:_____

Date:_____