DIANA FRANCIS HAND THERAPY

Patient Details Record

Please type directly below, save the pdf and send it as an attachment to us at: **info@dianafrancis.com.au**

Title: ________ First Name: ______________________ Surname: ______________________

Preferred Name: ______________________ Date of Birth: ______________________

Street Address: ______________________

Suburb: ______________________ Postcode: ______________________

Email Address: ______________________

Mobile Ph: ______________________ Home Ph: ______________________

Occupation: ______________________ Medicare No: ______________________

Next of Kin: ______________________ Relationship type: ______________________

Contact No: ______________________ Consent to contact: **Yes** **No**

PARENT/GUARDIAN *for patients under 18 years:*

Name: ______________________ Contact Ph: ______________________

Postal Address: *(if different to above)* ______________________

DOCTOR INFORMATION *Please complete all details below:*

Referring Doctor: ______________________

Clinic Name: ______________________

Clinic Address: ______________________

Usual Family Doctor: *(if different to above)* ______________________

Clinic Name: ______________________

Clinic Address: ______________________

MEDICAL HISTORY *Please complete all details below:*

Relevant Medical History: ______________________

Allergies: **No** **Yes –** list allergies: ______________________

Diabetes: **No** **Type 1** **Type 2**

Infectious diseases: **No** **Yes –** list diseases: ______________________

Previous hand injury or surgery: ______________________

____

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ACCOUNT DETAILS *Please complete all that apply to you:*

Aged or Disability Pension

Do you have an **aged** or **disability pension card**? **Yes** **No** *If yes, please provide the following details:*

Pension Type: ____________ CRN: ____________ Expiry: ____________

Please note *only patients with aged or disability pension cards are entitled to receive the pension rate.*

Workcover

Is your visit today related to a Workcover claim? **Yes** **No** *If yes, please provide the following details:*

Employer/Business Name: ____________

Employer Address: ____________

Accounts Contact Name: ____________

Accounts Phone or Email: ____________

Injury: ____________

Claim No:* ____________ Insurer: ____________

You are responsible for payment of your account until you have a current claim number

TAC

Is your visit today related to a TAC claim? **Yes** **No** *If yes, please provide the following details:*

Claim No:* ____________ Date of Accident: ____________

You are responsible for payment of your account until you have a current claim number

Veterans Affairs

Is your visit today related to Veterans Affairs? **Yes** **No**

Veterans Affairs Card No: ____________ Card Colour: ____________

You are responsible for payment of your account until you have a current claim number

Our trading terms provide that in the event of this account remaining unpaid and being referred to a debt collection agency and/or law firm; all collection and legal demand costs will be added to the account.

I understand that if I do not provide 24 hours notice of cancellation of my appointment that a cancellation fee will apply. This fee is payable by myself and is not covered by Medicare, Workcover, TAC or Veteran's Affairs.

Please Note: Accounts are to be paid on the day of consultation

Signed: ____________ Date: ______/______/______