Full Name			
Preferred Name			
Salutation (circle)	Mr	**Gender (circle)**	Male
Date of birth			
Address			
Suburb/Post code			
Mobile Phone			
Home Phone			
Occupation			
Email			
Emergency Contact	**Name/their relation:**		
	Their contact number:		
Your GP	**GP name:**		
	Clinic name:		

How did you find out about us? Please tick all that apply

- ☐ Allied Health practitioner: _____
- ☐ GP or Specialist: _____
- ☐ Word of mouth: _____
- ☐ Our website
- ☐ Google search
- ☐ Social Media: Facebook, Instagram, Twitter, YouTube
- ☐ Other: _____

Do you consent to:

- Your email being added to our clinical communications database for the purpose of communicating with you as a patient of this practice? ☐ Y ☐ N
- Discussion of your treatment with health professionals involved in your care? ☐ Y ☐ N
- Us contacting your referrer (if applicable) to thank them for recommending us? ☐ Y ☐ N

If you're under a third-party claim (eg Return to Work or motor vehicle claim), do you consent to:

Us communicating with other parties involved in the management of your claim? ☐ NA

Thismay include (but not limited to) case managers and return to work coordinator. ☐ Y ☐ N

Please note, we require at least 24 hours' notice for the cancellation or rescheduling of appointments otherwise the full fee will be charged. I acknowledge I'm responsible for payment of my account and any costs incurred in the collection of monies owed.

I also acknowledge that my personal information may be shared with other health practitioners and businesses that are operating at Move for Better Health Centres and are involved in my care. To view our full privacy policy, ask our admin team or alternatively you can view it on our website.

Signature _____ Date _____