

INTAKE FORM (Confidential)

TITLE: _____ FIRST NAME: _____ LAST NAME: _____

ADDRESS: _____

CITY/TOWN _____ STATE _____ P/C _____

PHONE (H) _____ (W) _____ (M) _____

EMAIL _____ D.O.B. _____

OCCUPATION _____

EMERGENCY CONTACT _____ PH. _____

HOW DID YOU HEAR ABOUT US? Doctors Referral Google/Internet Friend/Colleague
 Trainer/Podiatrist/Other Health Professional Other Advertising

NAME OF REFERRER (If Known) _____

Work Cover/Third-Party Payer Patients Only

Insurer's Name: _____

Employer: _____

Case Number: _____

Case Manager: _____

Phone: _____ Fax: _____

Thank you for your payment at the time of consultation. Health fund rebates can be claimed directly provided you carry your card with you. The gap in payment can be made using EFTPOS, cash or cheque. We accept VISA, MASTERCARD, BANKCARD and AMEX.

Please be advised that unattended appointments and late cancellations within 3 hours of a scheduled time will incur a fee of \$50.

Signed: _____

Date: _____