Patient Intake Form

If you require assistance, please do not hesitate to ask.

Patient Details:

Title: Mr / Ms / Mrs / Miss / Dr		
First Name:	**Surname:**	D.O.B:
Address:	Suburb:	Post Code:
Phone: (H)	(W)	(M)
Email:	Occupation:	
What is the reason for your appointment?		
Body Area/s Injured:	Date Of Injury / Recurrence:	
Sporting Code:	Player Position:	

GP/Treating Doctor Details (if known):

Doctor Name:	Phone:
Address:	Date of Referral:

Referrer (How did you hear about Ethos Health?)

GP/Treating Dr	☐	Employer	☐	Family/Friend*	☐	Other _____
Specialist	☐	School	☐	Sports Club	☐	
Radio	☐	Web	☐	Yellow Pages	☐	
Referrer Name:						
Referrer Address:						

*Family/Friend referrers will receive a **$20 Ethos Health gift voucher** if contact details are provided.

Health Fund / Insurer Information (if known):

Insurer:	Membership Number:
Phone:	Fax:

Consent to Release Information

I authorise Ethos Health to obtain, release or discuss information, either written or verbal, concerning relevant aspects of my treatment program, with representatives of the following agencies:

☐ School ☐ Referring GP ☐ Specialist
☐ GP ☐ Coaching Staff

Other: _____

ethos HEALTH

Please read the following information carefully and tick, sign and date where indicated.

- ☐ I understand that I may change or cancel the authority to obtain or release information.
- ☐ I understand that I am responsible for treatment expenses.
- ☐ I understand that any expense, costs or disbursements incurred by Ethos Health in recovering any outstanding monies including debt collection fees and solicitor costs shall be paid by I (patient), providing that those fees do not exceed the scale charges as charged by that debt collection agency/solicitor plus any out of pocket expenses.
- ☐ I understand that I (patient) may be responsible for the payment of a cancellation fee if my appointment is cancelled with less than 24 hours notice.
- ☐ I understand the terms and conditions of attendance and agree to abide where possible.
- ☐ I would like to receive information from Ethos Health including special promotions and offers.

Client Name: _____ DOB: ____ / ____ / _____

Student Signature: _____ Date: ____ / ____ / _____

Parent / Guardian Signature: _____ Date: _____ / _____ / _____

Office Use only:

Private / Non- HF

File #: ___ ___ ___ ___ ___ Date: ___ ___ / ___ ___ / ___ ___ ___ ___ Admin: ___ ___ AHP: ___ ___

Outcome Information:

Ax DOR: DOA: Quest Type: VAS RTW Code PID/SD/Unfit/Referred/ D/C

D/C DOD: No of Rx's: Quest Type: VAS RTW Code PID/SD/Unfit/Referred/ D/C

Exercise Physiology:

DOI: DOD:

No of Rx's: RTW Code PID/SD/Unfit/Referred/ D/C

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Charlestown Practice
2/12 Smith Street
Charlestown, NSW 2290
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F (02) 4920 6422

Mayfield Practice
32 Industrial Drive
Mayfield, NSW 2304
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Singleton Practice
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