



Patient Registration Form

Title _____ First name _____ Surname _____

Address _____

Postcode _____

Email _____

Your email is used for appointment reminders. We also produce a quarterly practice newsletter that many patients find informative. Please tick if you do not wish to receive this

Tel home _____ Work _____

Mobile _____ Date of birth ____ / ____ / ____

Who referred you for physiotherapy? Self / GP / consultant / other? _____

How did you hear about this clinic? Internet / word of mouth / doctor / other _____

In what part of the body is the injury located? _____

Occupation _____

GP Name and address _____

Do you give us permission to write to your G.P informing them of your attendance at our clinic **YES/NO**

Consultant's name and address _____

BUPA POLICY HOLDERS

If you are insured with BUPA we are able to invoice your insurer directly for the cost of your treatment. Please fill in the following details. Do be advised that should your insurance not cover the full cost of treatment, the difference remains your responsibility.

Policy holder _____ Policy Limit _____

Insurance Company _____ Excess _____

Policy/Member No. _____ Claim/auth. No. _____

Consent and cancellation policy

I consent to physiotherapy examination as deemed necessary by the physiotherapist. I understand that any procedures will be fully explained to me before treatment begins. I understand that I am responsible for the full cost of my treatment.

I understand that should I fail to attend an appointment without giving at least 24 hours notice then I will be liable for the full cost of the treatment.

Signature _____ Date _____