New Patient Registration Form

Your Details	
Title ……..	Address ……
Forename……	…….
Surname ……	…….
Male ☐ Female ☐	…… Post Code ……
Date of Birth ……	Telephone …….
Email ……	Mobile …….

Payment	
Self Funding ☐	Insurance ☐

Referral and Insurance Details	
How did you find us? …….	
…….	Medical Insurer ……
GP Name ……	Membership Number……
GP Practice……	Auth/Claim No……
	Policy Holder……
	Excess? Yes ☐ No ☐ Amount £….. Sessions……

Next of Kin	
Name …….	
Relationship ……..	Contact No ……

Agreement

The responsibility for the settlement of the physiotherapy account is and remains at all times the responsibility of the patient and/or guarantor. I hereby undertake to pay SB Physio Ltd (the Practice) for services and materials relating to my treatment as a private patient including any circumstances where medical insurance or third party proves not to cover the specific course of treatment. I declare that to the best of my knowledge the information given on this form is true and complete. I have read and understood the Privacy Policy and consent to assessment and treatment.

Please note that 24 hours notice must be given for cancellation of a session. If you fail to attend your appointment without 24 hours cancellation you may incur the full cost of the treatment session

Insured/Intermediary Patients

I hereby give authorisation to SB Physio Ltd to submit claims relating to my/the patient's treatment to my/the patient's insurer on my/their behalf. This includes the sharing of all relevant information including medical reports and notes. I confirm that I have given my explicit consent, within the meaning under *General Data Protection Regulation (2018)*, for my/the patient's personal data and medical information to be processed in relation to this claim and all subsequent treatment. I undertake to inform the Practice of any relevant excess payments that are due on the insurance policy.

To opt out of email reminders please tick ☐ To opt out of text reminders please tick ☐

I agree to these terms and conditions

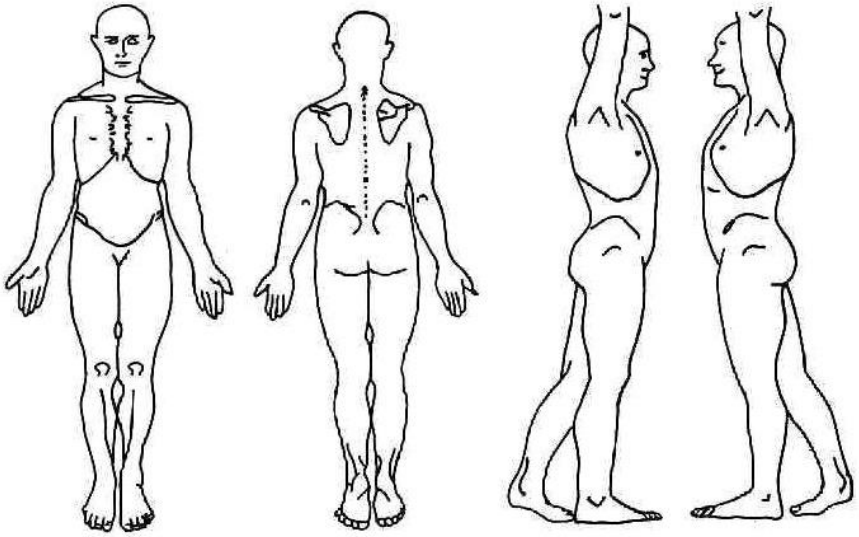
Signature Date

Patient or guardian if under 16

New Patient Registration Form

Your Details	
Name……	Date of Birth ……

Please explain the reason for your visit (e.g. back pain/unable to reach up, etc)



Where does your pain occur? (Please mark on the diagram with an 'X')

Please score each area of pain (on the diagram) from: 0 (No pain) to 10 (Extreme pain) Please mark on the any areas of numbness or pins and needles with an 'O'

Approximately how long have you been suffering with this pain? (Please tick 1)

Less than 1 week ☐ 3 months to 1 Year ☐
1 week to 1 month ☐ Over a year ☐
1-3 months ☐

Please rate your pain on severity from 0 (no pain) to 10 (extreme pain, at these different times of day		
Morning 0 1 2 3 4 5 6 7 8 9 10	Afternoon 0 1 2 3 4 5 6 7 8 9 10	Evening 0 1 2 3 4 5 6 7 8 9 10

Please tick all symptoms that you have ever had, even if they do not seem related to your current problem

☐ Headaches	☐ Abnormal Bladder	☐Morning Stiffness	☐ Epilepsy
☐ Blurred Vision	☐ Abnormal Bowel	☐ Arthritis	☐ Panic Attacks
☐ Dizziness	☐ Muscle Weakness	☐ Diabetes	☐ Fatigue
☐ Fainting	☐ Chest Pain	☐ Prostate trouble	☐ Cancer
☐ Ringing in ears	☐ Palpatations	☐ Asthma	☐ Depression
☐ Pins and needles	☐ High blood pressure	☐ Breathing problems	☐ Sleep Problems
☐ Numbness	☐ Allergies		

Women Only ☐ Hot flushes/Night sweats ☐Heavy Menstration ☐ Painful menstruation ☐Irregular Cycle

Is there any chance you may be pregnant Yes ☐ No ☐

Investigations (MRI, X-ray ect)?

Any other Relevant Information?