

# WOMEN'S HEALTH AND PELVIC FLOOR PHYSIOTHERAPY

## ACQUAINTANCE FORM

Your personal details need to be accurate, up-to date and complete in order for the practice to provide you with ongoing efficient treatment and advice. Please fill in the following.

Surname (Miss/Ms/Mrs/Dr): \_\_\_\_\_

First Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Post Code \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_

Mobile \_\_\_\_\_

Email Address: \_\_\_\_\_

How did you find out about the practice: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Health Fund: \_\_\_\_\_

Membership No: \_\_\_\_\_

***Fees are payable at time of consultation. Rebates are claimable from private health funds. Should payment of fees present a problem, please discuss with the physiotherapist treating you.***

**I consent to a vaginal examination if it is required.**

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_