G. LUKONGA PHYSIOTHERAPY

Move Better. Live Better.

NEW PATIENT REGISTRATION FORM

1. PERSONAL INFORMATION

Title (Mr/Mrs/Ms/Dr): _____ Full Name & Surname: _____

ID / Passport Number: _____ Date of Birth (DD/MM/YYYY): _____

Nationality: _____ Preferred Language: _____

Email Address: _____ Cell Phone Number: _____

Gender: ☐ Male ☐ Female ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Other

Home Phone Number: _____

2. CONTACT INFORMATION

Residential Address: _____

Suburb: _____ City: _____ Province: _____ Postal Code: _____

3. MEDICAL INFORMATION

Do you have a Medical Aid? ☐ Yes ☐ No

Medical Aid Name: _____ Main Member Name: _____

Main Member ID Number: _____ Relationship to Main Member: _____

Do you have any chronic conditions? If yes, please specify: _____

Are you currently taking any medication? ☐ Yes ☐ No If yes, please specify: _____

Any allergies? ☐ Yes ☐ No If yes, please specify: _____

Have you had any surgeries? ☐ Yes ☐ No If yes, please specify: _____

4. EMERGENCY CONTACT

Contact Name: _____

Relationship: _____

Cell Phone Number: _____

Alternative Phone Number: _____

5. REFERRAL INFORMATION

How did you hear about us?

☐ Doctor / Healthcare Professional ☐ Family / Friend ☐ Website

☐ Social Media ☐ Walk-in / Signage ☐ Other: _____

Referring Doctor / Practitioner (if applicable): _____

6. REASON FOR VISIT

_____

Date when symptoms started: _____

On a scale of 1–10, how would you rate your pain?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

7. CONSENT & DECLARATION

I hereby confirm that the above information is true and correct to the best of my knowledge.
I consent to receiving physiotherapy treatment and understand that I may ask questions at any time regarding my treatment.
I understand that my personal information will be kept confidential and used only for the purposes of my care.

Signature: _____ Date (DD/MM/YYYY): _____

+27 11 845 7027
+27 11 845 7027
admin@lukongatherapy.co.za
121 Wooton Avenue crn Harrison street, Benoni
Life Dalview Hospital
11 Hendrik Potgieter Road (Ref. House 2 Dr. Malanda)
Dalview 1541, Brakpan

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