Right Sounds, 5/6 Walker Street, Torquay 3228
Phone: *0491 091157*
Email: *info@right-sounds.com.au*

CLIENT REGISTRATION FORM

Name:_____
Age: _____ **Sex:** _____ **Date of Birth:** _____
Address: _____
Home Address:_____
Phone Number: _____ **Work:**_____ **Other:** _____

Parent/Carer's Name:_____
Parent/Carer's Address: _____
Phone Number: _____ **Email:** _____
School Name:_____

GP's Name: _____ **GP's Contact No.:** _____
Referrer's Name *(N/A if self-referral)*: _____
Referrer's Address: _____

How did you hear about me?

_____
_____

Presenting complaint: - brief description of problem

_____
_____

PREVIOUS PATHOLOGIST INFORMATION *(N/A if not applicable)*
Speech Pathologist's Name: _____
Speech Pathologist's Contact No.: _____

Provide recent reports (12 months)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Medical History *(describe any relevant medical conditions and/or allergies if applicable)*

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies:_____

Hearing Condition: __ Normal __Hearing Loss
Most recent date of hearing test *(if possible)***:** _____
Vision *(with glasses)***:** __ Yes __ No

I consent for Right Sounds to collect and record my health information and share this with other providers only when necessary. I understand my privacy will be respected.

Fees:
All fees are payable on the day of consultation by credit card. Thank you.

Signed: _____ **Name in print:** _____ **Date:** _____