NEW PATIENT REGISTER

At Canberra Podiatry, we take a thorough history in order to give you the best possible care. In addition, consenting to us corresponding with your existing healthcare network will allow you to achieve the best possible outcome. Thank you for your co-operation.

Patient's Full Name: _____

Preferred Name: _____ Date of Birth: _____

Parent/Guardian (if patient is under 18 years): _____

Address: _____ Suburb: _____

Phone Numbers: Home: _____ Work: _____ Mobile: _____

Email: _____

GP Name: _____

Private Health Fund: _____ Membership No: _____ID _____

Medicare No: _____ - _____ Ref No: _____ Expiry Date: _____

DVA No: _____ Expiry Date: _____ Card Type: Gold/White (Please circle)

Centrelink Aged Pension No: _____ Expiry Date: _____

NDIS Patient: Yes No (Please circle) If yes please provide NDIS Number: _____

Is this consultation as a result of an insurance claim? No Yes (Please circle)

If Yes, please request and complete the **Compensation Declaration** form from our **reception staff**.

MEDICAL HISTORY			
Do you suffer from;	**YES**	**NO**	**Are you taking any Medication for these conditions? If so, please list them below**
Diabetes			
High Blood Pressure			
Peripheral Vascular Disease			
Heart Disease			
Arthritis			
Connective Tissue Disease			
Epilepsy			
Asthma			
Allergies			
Other (Please specify)			

How did you find out about us? (Please circle)

Radio Social Media White/Yellow Pages Website Google ad Previous Patient

Referred by Surgeon/GP/Professional Name of Referrer: _____

Referred by friend or family member Name of Referrer: _____

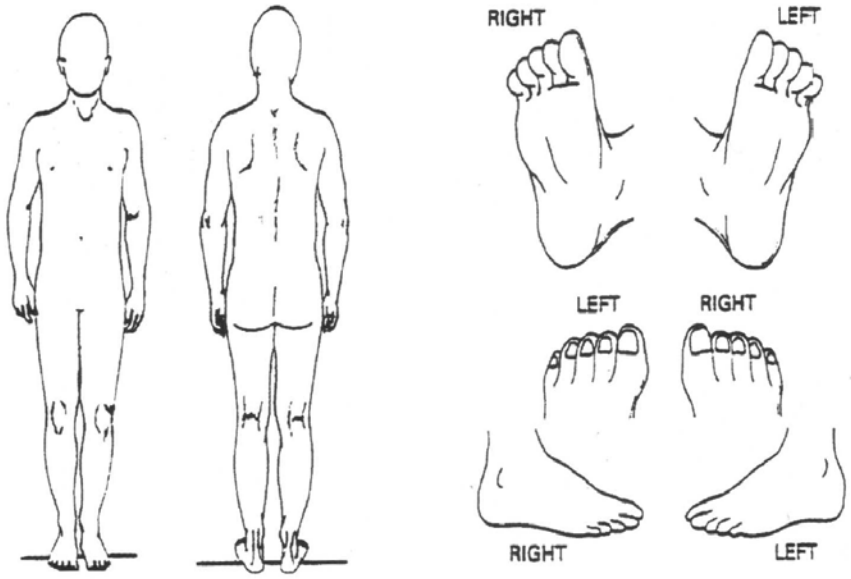
YOUR CURRENT SYMPTOMS

Please circle those that apply:

Dermatological (skin/nails)	Difficulty reaching and treating nails/feet	Curved or ingrown nails
Thick, fungal or discoloured nails	Painful callus, corns, wart	Foreign object in your foot
Sore Heels	Pain in Joints	Sore Muscles
Painful Ankles	Stress fractures/Broken bones	

Other (please give details) _____

Please mark on the diagrams below where you find it painful or where you are currently being treated for other pain as well. Often pains can be related.



PATIENT CONSENT

In line with the provisions of the Commonwealth Privacy Act (1988) and the National Privacy Principles, your consent is required for the collection and storage of your personal and health information. The information you provide will form part of your medical record and be stored in our computer system.

It is necessary for us to collect personal information from our patients (and sometimes others associated with their health care) in order to look after their health needs and for associated administrative purposes.

No access to your health or other personal information, in any form, will be provided to any unauthorized person or to any person or organization outside of this practice without your express, written permission.

* I consent to my Podiatrist recording and storing the information I have provided. I understand that this information will form part of a computerized database. Yes/No (Please circle)

* In the event that I need to be referred for further tests and/or Investigations, I give consent to my Podiatrist disclosing essential personal and health information for that purpose. Yes/No (Please circle)

* I consent to my Podiatrist discussing my presenting condition with practitioners in my current health network. Yes/No (Please circle)

* I understand that I am responsible for payment of the full amount of the fees resulting from any consultations and/or procedures. Yes/No (Please circle)

NAME: _____ **SIGNATURE:** _____

DATE: _____