NEW PATIENT REGISTRATION FORM

Title: ______ Full Name: ____

Preferred Name: ________________________________ Date of Birth: ____________

Parent/Guardian (if under 18 years): ____

Address: ____________________________ Suburb: ________________ Post Code: ______

Phone Numbers: Home: ____________ Work: ______________ Mobile: ________________

Email: ____

GP Name: _______________________ Practice:_________________________________

Private Health Fund: ________________________ Membership No: ____________ID ______

Medicare No: __________ - ___________ Ref No: _________ Expiry Date: ____________

DVA No: __________________ Expiry Date: ______________ Card Type: Gold ☐ White ☐

NDIS Patient: Yes ☐ No ☐ NDIS Number: ____________________

Is this consultation the result of an Insurance Claim? Yes ☐ No ☐

Employer: _________________________ Insurance Company: _____________________

Claim Number: ___________ Telephone: ____________ Email: _____________________

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

Referred by friend or family member Name of Referrer: ___________________________

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)			

What are your main concerns today: ____

How long have you had this problem: ____

Exercise/Activities: ________________________________ Frequency: ________________

YOUR CURRENT SYMPTOMS

Please choose those that apply:

☐ Dermatological (skin/nails) ☐ Difficulty reaching and treating nails/feet ☐ Curved or ingrown nails

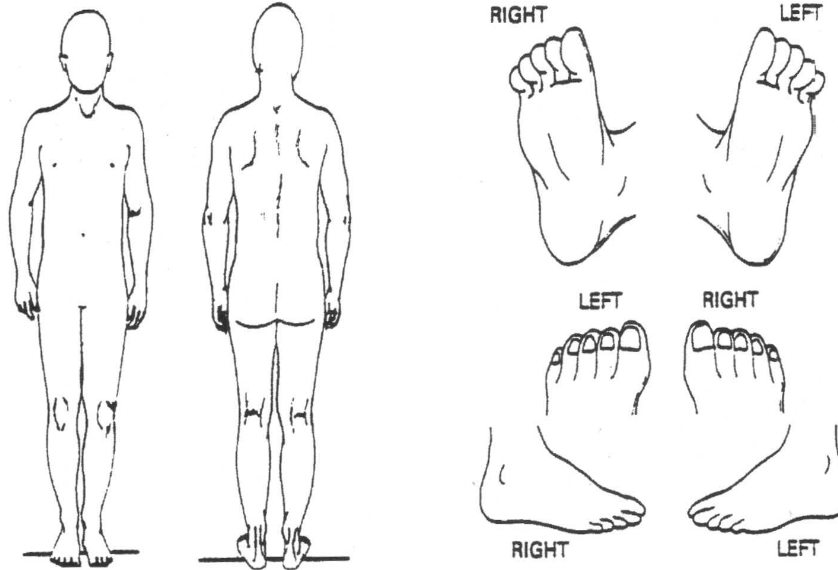
☐ Thick, fungal or discoloured nails ☐ Painful callus, corns, wart ☐ Foreign object in your foot

☐ 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.



How did you find out about us?

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

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 ☐

* 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 ☐

* I consent to my Podiatrist discussing my presenting condition with practitioners in my current health network. Yes ☐ No ☐

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

Name: ____ Signature: ____

Date: ____