Podiatry & Orthotic GROUP

PATIENT REGISTRATION

Date: / /

Title (please circle one): Miss / Ms / Mrs / Mr / Dr or Other

Given Name:_______________________________ **Surname:**_______________________________________

Email Address:____

Phone (H)__________________________ **Mobile:**____

Date of Birth: / / **Occupation:**____

Address:____

Suburb: ______________________________________**Post Code:**______________

GP's name:____

Are you a Pensioner (please circle) Yes / No

Do you have Private Health Insurance (please circle) Yes / No

How did you hear about our clinic?

- ☐ Referred by your doctor
- ☐ Referred by a friend
- ☐ Other______________________________

Internet / website

Yellow page

Do you have Allergies? Yes / No List ____

MEDICAL HISTORY

Please select if any apply to you:

- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Heart Attack
- ☐ Heart Valve Condition
- ☐ Irregular Heartbeat
- ☐ Other Heart Condition
- ☐ High Blood Pressure
- ☐ Anaemia
- ☐ Blood Clots
- ☐ Pulmonary Embolism
- ☐ Poor Blood Flow to Feet
- ☐ Bleeding/bruising tendency
- ☐ Stroke
- ☐ Pulmonary/ Lung Disease
- ☐ Asthma
- ☐ Kidney Transplant or Dialysis
- ☐ Kidney Disease
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Systemic Lupus Erythmatosis
- ☐ Osteoporosis
- ☐ Psoriasis
- ☐ Raynauds Phenomenon
- ☐ Stomach Ulcers or Reflux
- ☐ Irritable Bowel Syndrome
- ☐ Hepatitis
- ☐ Alcohol Dependency
- ☐ Drug Dependency
- ☐ Seizures
- ☐ Migraines
- ☐ Chronic Back Pain
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep Apnoea
- ☐ Cancer
- ☐ HIV/ AIDS
- ☐ Keloid or Scar Problems
- ☐ Other:

Please list any **MEDICATIONS** you are now taking, both prescription and over the counter. (If you have a referral your medications may be listed on the referral letter from your GP)

Name of medication	Dosage (eg. 10mg)	How often do you take (eg. once daily)
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Privacy Statement:

Recent requirements under the Health Privacy Act state that we now require your consent to collect information about you. We require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administration purposes in running our practice
- Billing purposes, including compliance with Health Insurance Commission requirements
- Relating your information to others involved in your care, including your general practitioner and specialists outside this practice. This may occur through referral to other doctors or for medical tests.

Please let us know if you do not want your records accessed for these purposes and we will note this in your record accordingly. If you consent to the handling of your information for the purposes set out above, please sign and date below.

____ Signature

Date: / /