BAYSIDE FOOT CLINIC

Title: (Please circle) Mr / Mrs / Ms / Miss

SURNAME: ______________________________ **FIRST NAME:**______________________________

ADDRESS: ____

SUBURB: ______________________________________ **POST CODE:** _____________________

PHONE: Home: ____________________________ Mobile: ______________________________________

Shoe Size: _______________________________ **DATE OF BIRTH**: ____________________________

EMAIL: ___________________________________ would you like patient updates/education? **Y**□ **N** □

EMERGENCY CONTACT: _______________________ **Relationship:** ___________________________

Phone: _____________________

Foot Concern:____

Private Health Insurance?: **Yes** □ **No** □ Company: _____________________________________

PLEASE CIRCLE APPROPRIATE ANSWER

1.	**Do you have pain in your feet?**	**Yes** □ **No** □
2.	**Do you have any skin or nail problems (Ingrown/discoloured toenails, corns, rashes or hard skin)**	**Yes** □ **No** □
3.	**Are you subject to pro-longed bleeding?**	**Yes** □ **No** □
4.	**Do you have Diabetes? (If yes, please complete questions on reverse side)**	**Yes** □ **No** □
5.	**Do you suffer side effects from Novocain, Penicillin or any other medicines?**	**Yes** □ **No** □
6.	**Have you had exposure to any high risk communicable Diseases?**	**Yes** □ **No** □

I believe the above answers to be correct to the best of my knowledge. I hereby give my permission to the treating Podiatrist to administer treatment, and/or perform such minor operative procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition. All accounts must be paid on the day of consultations. Where a third party is paying and payment is rejected you the patient is responsible for payment. We require your consent to collect personal information and occasionally medical history about you, and to use this information in the following ways 1. to contact you regarding results, recalls and reminders for your footcare. This may be in the form of SMS, email, phone or letter. 2. Administrative and billing purposes. 3. Disclosure to others involved in your footcare including your GP/referring doctor and/or other relevant specialists. 4. To comply with any legislative or regulatory requirements. Please note that you may access any personal information held on request. You may decline to have your information used in all or some ways outlined, but this may influence our ability to manage your foot care. A copy of our privacy policy is available on request. Please sign below if you have read, understood and consent to the conditions and handling of your personal information as outlined above.

Signature:____ **Date:** ___________________________

Please Note: All nail polish must be removed prior to any nail treatment by the Podiatrist. Please see reception staff if you require assistance.
How did you hear about us? ____

For Diabetics only – please complete questions below.
(Please circle)

1. Are you type 1 or 2?
2. How long have you been diagnosed with Diabetes? ___________________
3. Do you have any sores on your feet that are not healing? YES / NO
4. Do you trip or fall often? YES / NO
5. Do you have any numbness in your feet? YES / NO