BaysideFootClinic

Shop 9, 39 Middle Street
Cleveland, QLD, 4163
Ph: 3821 4524

Patient Information – New Patient Form

Name: Mr / Mrs / Ms / Miss / Master / Dr (Please circle)

Surname: _____ First Name: _____

Address: _____

Suburb: _____ Post Code: _____

Phone: (Home) _____ (Mobile) _____

Email: _____ Date of Birth: _____

Private Health Fund?: Yes ☐ No ☐ Health Fund Name: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

GP's Name & Clinic: _____

Do you consent to us contacting your GP regarding your case if necessary? Yes ☐ No ☐

Medical/Health History

Are you in good health? Yes ☐ No ☐ (If no, please provide details below)

_____

Do you have any Allergies? _____

Current Medications: _____

_____

Are you on any blood thinners/subject to prolonged bleeding? Yes ☐ No ☐

For Diabetics only – Please complete questions below

Are you Type 1 or 2? _____

How long have you been diagnosed with Diabetes? _____

Do you have sore on your feet that are not healing? Yes ☐ No ☐

Do you trip or fall often? Yes ☐ No ☐

Do you have any numbness in your feet? Yes ☐ No ☐

Please Turn Over Page

What foot concerns bring you to the Podiatrist today? _____

Do you have pain in your feet? Yes ☐ No ☐

Do you have skin/nail problems? Yes ☐ No ☐
(Ingrown/discoloured toenails, corns, rashes or hard skin?

Please tick if you have or have had any of the following:

☐ Back Problems	☐ Tired Feet	☐ Heart Disease	☐ Foot/Leg Cramps	☐ Ulcers
☐ Asthma	☐ Rheumatoid	☐ Hypertension	☐ Stroke	☐ Gout
☐ Osteoarthritis	☐ Cancer History	☐ Angina	☐ Poor Circulation	☐ Epilepsy
☐ Falls in the last 12 months		☐ Fractures / Sprains:		

Please provide any other details that you feel may be relevant to your appointment today:

_____

Where did you hear about Bayside Foot Clinic?

☐ Doctor	☐ Website	☐ Facebook
☐ Search Engine	☐ Friend/Family Name:	

Patient Consent

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.