Welcome to Your Foot Doctor Podiatry

Please **fully complete** the form below to ensure our database is accurate. All information collected is kept secure and confidential.

Full Name:_____Preferred:_____Male ☐ Female ☐

Date of Birth:_____ Occupation:_____

Residential Address:_____

Postal Address (If different from above):_____

Home Phone:_____Mobile:_____Work Phone:_____

Email Address:_____

Emergency Contact:_____Phone:_____Relationship:_____

Private Health Insurance (if applicable): _____

Have you been given an EPC Medicare Care Plan from your GP? Yes ☐ No ☐

If **YES**, Medicare Number:_____Ref # on card:_____Expiry:____/____

Do you hold any concessions? Pension ☐ DVA (White/Gold) ☐ Health Care Card ☐

Concession Card #:_____Expiry:_____/_____/_____

Are you with the NDIS? Yes ☐ No ☐ If **YES** please see receptionist for additional form for you to complete.

Your GP Name and Clinic:_____

Please note medical conditions/surgeries/medications can impact on the treatment we provide you and it is essential that our Podiatrists are fully aware of your medical history.

Please circle if you have any of the following:

Diabetes Arthritis Heart Conditions Foot/Knee/Hip Surgery High Blood Pressure/Cholesterol

Any other medical conditions:_____

Medications/Supplements:_____

Allergies:_____

Sports Played/Hobbies:_____

Your reason for visiting us today:_____

Do you consent to pay for all treatments and/or materials supplied at the time of treatment Yes ☐ No ☐

Do you consent to Dry Needling if your Podiatrist suggests as an appropriate form or treatment? Yes ☐ No ☐

Do you consent to your Podiatrist discussing your condition/treatments with other Health Practioners that could benefit your conditions? (E.g. Physiotherapist, Massage Therapist, Surgeon) Yes ☐ No ☐

Please note a fee may be charged should you cancel your appointment without 24hr notice or for non-attendance.

Thank you ☺

Print name:_____

Signed:_____ Date:_____