PATIENT INFORMATION SHEET

Welcome to Procare Podiatric Medicine & Surgery

Mr / Mrs / Ms / Miss / Master / Dr / Other *(please circle)*

SURNAME: ____________________ FIRST NAME: ____________________D.O.B:___/___/________

ADDRESS: ____

____ POSTCODE: ___________________

HOME PHONE: ___________ WORK PHONE: ___________ MOBILE: _________________________

OCCUPATION: _________________

USUAL DOCTOR: __________________ADDRESS: ____

HEALTH FUND: ________________CENTRELINK PENSION NO: ____________________ *(If applicable)*

HOW DID YOU LEARN OF THIS PRACTICE? *(Please tick)*

- ○ Dr or Specialists' referral: ______________
- ○ Google Search/Facebook
- ○ Newspaper/Flyers
- ○ Friend/ Family
- ○ Other Health Practitioners (eg. physiotherapist)
- ○ Passing by/ Driving by
- ○ Sports Trainers

Other: __________________

DO YOU SUFFER FROM *(Please Tick)*

○Diabetes	○Arthritis	○Anaemia	○Blood Disorders
○Heart Conditions	○Nerve Disorders	○Skin Disorders	○AIDS/HIV
○Cancer	○Liver Diseases	○Poor Circulation	○Thyroid Disease
○Kidney Diseases	Others:		

ALLERGIES: ____

CURRENT MEDICATIONS TAKEN: ____

PREVIOUS PODIATRY TREATMENTS? YES/ NO If YES-WHAT? ______________________________

DECLARATION & CONSENT

- *I hereby give authority for practitioners of Procare Podiatric Medicine & Surgery to examine, treat and authorize diagnostic techniques in the treatment of my complaint.*
- *I authorise Procare Podiatric Medicine & Surgery to contact any health provider with whom I have previously consulted and request disclosure of relevant personal health information to assist in appropriate treatment. I also consent to that health provider disclosing such information.*
- *I authorise the release of relevant information to referring practitioners, insurers, employer and/or other related third party relating to my treatment.*
- *I understand that I am responsible for all accounts relating to consultations, treatments, products or other services provided by practitioners of Procare Podiatric Medicine & Surgery.*
- *I am aware that Medicare does not cover any of this fee, unless referred by my general practitioner under TCA/EPC/CDMP plan.*
- *I accept that additional charges may be incurred as a result of outstanding accounts.*
- *I understand that Procare Podiatric Medicine & Surgery, complies with the Privacy Act (1988) and as part of their Privacy Policy, is committed to protecting the privacy of individuals and their personal information. The purpose of collecting my personal information is to provide quality medical, health related services, associated record and account keeping. I understand that I have the right to request access to my information, and that Procare Podiatric Medicine & Surgery makes every effort to manage my information in accordance with the National Privacy Principles. I understand that I may withdraw my consent for Procare Podiatric Medicine & Surgery to use and disclose my personal information (except when legal obligations must be met).*

SIGNATURE: ____________________ DATED: ___/___/______

(Parent/ Legal guardian if patient under the age of 18)