New Patient Form
Dietitian

About You

Title: Mr. Mrs. Miss. Ms (please circle)

Name: DoB::

Address:

Suburb: Postcode:

Email: Contact No:

Medicare Card Number: Individual Reference No:

Emergency Contact Name and phone:

Are you covered on the National Disability Insurance Scheme (NDIS) ◯ Yes ◯ No

GP's Name:

GP's Contact Number:

GP's Clinic Name:

Workers Compensation or CTP Details

Insurer: DOI:

Claim Number:

Case Manager's Name:

Case Managers Contact No:

Case Manager's Email:

How did you hear about Blue Mountains Podiatry?

◯ Google Search ◯ Sporting Club/Community Event ◯ Blue Mountains PodiatryWebsite

◯ Social Media ◯ Patient/Friend ◯ Location/Signage ◯ Your GP

Please continue on the next page

New Patient Form
Dietitian

BLUE MOUNTAINS Podiatry

Health History

- ◯ Deficiencies
- ◯ Allergies
- ◯ Bacterial Infection
- ◯ Female Reproduction
- ◯ Anxiety
- ◯ Neurological
- ◯ Cardiovascular
- ◯ Digestion
- ◯ Liver
- ◯ Mood
- ◯ Inflammation
- ◯ Thryoid
- ◯ Fungal Infection
- ◯ Skin
- ◯ Stress
- ◯ Sleep
- ◯ Other: ______________________________

____

____

By signing below you are giving consent for all practitioners at Blue Mountains Podiatry to access your patient file including all medical, health and treatment notes. If there are any areas of your personal details you do not want made available to other practitioners please notify your treating practitioner.

By signing below you are acknowledging that we have a 24-hour cancellation policy and if you cancel within 24 hours of your scheduled appointment a non-deductible fee of $50 will be charged.

I acknowledge that I have carefully read all of the above information appropriate to the practitioner I am seeing, and that I understand and agree to each point that is made. Once you have given consent, you may withdraw it at any time in writing.

I hereby acknowledge that the information given is true, and I consent to treatment at this practice and the costs incurred and authorise any relevant information to be forwarded to other health practitioners involved in the management of the condition/s when required.

Patients Name: ______________ Signature: ______________ Date: ______________

Parent/Guardian Name: ______________ Signature: ______________ Date: ______________