

New Patient Form

Podiatry



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

DVA Pensioner Senior Health Care

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 OnePointHealth Website
 Social Media Patient/Friend Location/Signage Your GP

Fee Schedule

Initial Consultation (all patients)	from \$95.00	Pro-Long Consultation/EPC (all patients)	from \$136.00
Standard Consultation/EPC	from \$88.00	Biomechanical Assessment	from \$177.00
Pensioner Rate Standard	from \$83.00		

Current Foot/Lower Limb Problems

- Heel Pain Flat Feet Diabetes Awareness & Care
 Arch Pain Knee Pain Ingrown Toenail
 Shin Splints Nails/Corns/Calluses Other _____

Health History

- | | | |
|--|---|--|
| <input type="radio"/> Abdominal / Digestive Problems | <input type="radio"/> Fibromyalgia | <input type="radio"/> Muscle, bone injuries |
| <input type="radio"/> Allergies | <input type="radio"/> Headaches or Migraines | <input type="radio"/> Numbness or tingling |
| <input type="radio"/> Arthritis | <input type="radio"/> Hearing Problems | <input type="radio"/> Phlebitis |
| <input type="radio"/> Asthma or Lung Conditions | <input type="radio"/> Heart, circulatory Problems | <input type="radio"/> Pregnancy |
| <input type="radio"/> Blood clots | <input type="radio"/> Hernias | <input type="radio"/> Endocrine Disorders |
| <input type="radio"/> Cancer / Tumors | <input type="radio"/> High / low Blood Problems | <input type="radio"/> Seizures |
| <input type="radio"/> Chronic Pain | <input type="radio"/> Infectious Disease | <input type="radio"/> Skin disorders |
| <input type="radio"/> Chronic Fatigue | <input type="radio"/> Lymph node Removal | <input type="radio"/> Stroke |
| <input type="radio"/> Depression | <input type="radio"/> Motor vehicle accident / trauma | <input type="radio"/> Varicose veins |
| <input type="radio"/> Diabetes | <input type="radio"/> Muscle or joint pain | <input type="radio"/> Vision problems / contact lenses |
| <input type="radio"/> Fatigue | <input type="radio"/> Kidney Issues | |
| <input type="radio"/> Osteoporosis/Osteopenia | | |

By signing below you are giving consent for all practitioners at OnePointHealth 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.

During the examination, assessment and treatment it may be necessary for your practitioner to make physical contact. Physical contact requires your express consent and you may withdraw consent at any time, at which point all physical contact will cease immediately. Please inform your practitioner if you feel uncomfortable at any time.

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: _____