



Welcome

In order for us to provide high quality treatment it is necessary that we have the following information. We require you to provide us with your medical history before treatment can occur. Your privacy is paramount, and will be protected. Our *Privacy Policy* is available on request.

Name: _____ Date of Birth: _____

Preferred Name: _____ Occupation: _____

Address: _____

Home Phone: _____ Mobile: _____

Email: _____

We are pleased to offer a complimentary appointment reminder service on the business day prior to your appointment. Please indicate your preferred reminder method ():

SMS/ Text Message Phone Email No reminder

Emergency Contact: _____ Relationship: _____

Phone: _____ Mobile: _____

What brings you to the Podiatrist today?

How long has this been going on?

What's been done so far to help you?

Why is it important to fix this now?

Where did you hear about Feetology? (please tick)

Signage Yellow Pages Local Book White Pages Pink Pages

Yellow Pages Online Google/ Yahoo/ Bing Facebook

Doctor Name: _____ Other (Pls specify): _____

Friend/ Family Name: _____

Medical History: _____

Medication: _____

Allergies: _____

Social History (Sports/ Leisure, Smoking, Alcohol): _____

GP Name: _____ GP Contact: _____

Private Health Insurance? No Yes Fund Name: _____

Patient Acknowledgement/ Consent: (please tick)

- I consent to podiatric treatment from Feetology Podiatry Centre Podiatrists
- I agree to give 24 hours' notice if I am unable to attend a scheduled appointment
- I understand that images of my feet and/or legs may be taken as part of my treatment and I consent to these images being taken, stored and utilised as part of my care
- I consent to the particulars of my care being discussed with relevant health professionals involved in my care
- I agree to this consent remaining valid until such time as I withdraw my consent.

Date: DD / MM / YYYY

Signed