INITIAL FORM

PERSONAL INFORMATION

Full Name :

Date Of Birth :
D D M M Y Y

Full Address :

Phone : Home Mobile

Emergency Contact :

E-Mail :

Have you seen a Podiatrist before? : Yes No

GP Name :

Private Health Insurer :

Pensioner? : Yes No Work cover? : Yes No

if yes to either question, please provide relevant documents

How did you hear about us? :

INITIAL FORM

MEDICAL INFORMATION

Do you have any allergies to latex, iodine, tea tree oil or local anaesthetic? : ☐ Yes ☐ No

Any other allergies? :

Please list your current medications :

Blood thinners eg aspirin or warfarin? : ☐ Yes ☐ No

Please tick all that apply :

- ☐ High blood pressure?
- ☐ High cholesterol?
- ☐ Stroke or TIA?
- ☐ Heart disease?
- ☐ Varicose veins?
- ☐ Thrombosis/clots?
- ☐ infectious diseases? HIV/AIDS/Hepatitis?
- ☐ Diabetes?
- ☐ History of MRSA/VRE?

THANK YOU FOR YOUR INFORMATION

INITIAL FORM

PRIVACY FORM

A & S Podiatry needs to collect information about you for the primary purpose of providing a quality service to you. In order to thoroughly assess, diagnose and provide therapy, we need to collect some personal information from you. If you do not provide this information, we may be unable to treat you.

This information will also be used for:
The administrative purpose of running the practice
Billing either directly or through an insurer or compensation agency
Use within the practice if discussing or passing your case to another practitioner within the practice for your ongoing management
Disclosure of information to your doctors or health professionals to facilitate communication and best possible care for you
In the case of an insurance or compensation claim, it may be necessary to disclose and/or collect information that concerns your return to work to an insurer or your employer.
To keep you informed about footcare

We do not disclose your personal information to overseas recipients.

To ensure the process of quality treatment provision, information about your assessment results and progress may be given to relevant other service providers, who are involved in your management. These may include your doctor, physiotherapist, specialists, insurer, solicitor or employers.

I have read the above information and understand the reasons for the collection of my personal information and the ways in which the information may be used and disclosed and I agree to that use and disclosure.

I give consent to treatment which may include taking photos/videos for future reference.

I understand that it is my choice as to what information I provide and that withholding or falsifying information might act against the best interest of my assessment and therapy progress.

I am aware that I can access my personal information on request and if necessary, amend my details that have changed.

SIGNED ____________ DATE ____________