Patient Registration Form

If there are any sections of this form that you do not understand, leave it blank and your podiatrist can go through it with you.

PERSONAL DETAILS		
First Name:	Last Name:	
Address:		
Postal Address (if different to above):		Postcode:
Date of Birth:	Age:	Occupation:
Phone:(Home)	(Mobile)	(Work)
Email:		
Name of GP:	Clinic:	
Do you have an Allied Health Care Plan? Yes / No If yes, please give to reception		
Do you have a referral from another health care provider? Yes / No If yes, please provide information to reception		
Have you had any tests/x-rays/scans etc. relating to today's appointment? If yes, please speak with reception		
Next of Kin/Parent/Guardian/POMA		
Name:		
Relationship to patient:		
Address:		
Contact number:		
Email:		
Person responsible for Account (write "as above" if the same)		
Name:		
Address:		
Email:	Contact number:	
Note: Payment is required on the day of consultation. A quote can be given prior to this for services to be provided. Please request a quote if needed. Agency or plan managed clients will be accepted; however payment on the day of appointment is required. We do not bill to a 3rd party. A non-attendance fee will be charged with less than 24-hours notice of cancelation.		
Do you consent to your podiatrist requesting further medical history, if required, to assist in your care? **If yes, please sign** **Consent Signature: …… Date: ……**		
A copy of the Australian Privacy-Principles is available at reception.		

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