Confidential Patient Form

Podiatry

Date: / /

Name:_____ Sex: M F Occupation:_____

Date of birth: ___/___/___Email: _____

Address:_____ Post Code: _____

Phone: (H)_____(W)_____(M) _____

Emergency Contact Ph:_____ Marital Status:_____No. Children:_____

Pensioner card O Healthcare card O Student card O

Health Cover: None O Private O With: _____

Reason for this visit: _____

Have you received treatment for this in the past? Yes_____ No___

Details of past treatment (who & when):_____

How did you hear about us?_____

Is this a Work Cover or MVA claim? Y N (If yes, Please ask reception for supplementary form)

Describe in your own words, any symptoms that you may have: _____

_____

_____

How did your condition start:_____

_____

Please rate the severity of your pain at the moment by circling number(s) below on the following scale: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme Pain) Do you feel you are:

Improving_____Deteriorating:_____Static:_____

Have you had any testing or x-rays for this condition?_____

Have you seen a Podiatrist before?_____

Please provide details (if relevant) of:

Accidents: _____

Operations:_____

Current Medications_____

Do you suffer or have you every suffered from:

Muscle Cramping ☐ Osteoporosis ☐

Diabetes ☐ Dizzy Spells ☐ Low Blood Pressure ☐

OFFICE POLICY

Our goal is to deliver an exceptionally friendly and prompt, professional service providing you with the best in Podiatry care. Our experience tells us that there are some key areas we need to focus on to ensure that you receive the **greatest benefit** from our services.

Mobile Phones: Out of respect for others, please turn off your mobile phone.

Recovery: Remember that healing and recovery takes time and not everyone heals/recovers at the same rate. If at any time during your care, you do not feel that you are responding as well as expected we would ask that you discuss this with your podiatrist. We want you to get the most from your care at *The Wellness Place, Bassendean.*

Excellence in Podiatry: In order to continue to provide the best, most up to date Podiatry care available we travel periodically to conferences and seminars. To keep your progress on schedule we will attempt to book your appointments around those times or else provide another highly qualified podiatrist to continue your care.

Fees and Your Account: Fees for private patients are due at the time of service. HICAPS and EFTPOS facilities are available at the front desk for automatic claiming through your private health fund. Workcover and DVA patient accounts will be sent directly to the appropriate body.

Referrals: The greatest compliment we can receive is the referral of a friend or family member. The referral of your family and friends is much appreciated as it will both sets them on the road to recovery and wellbeing and plays a vital role in the success of our business.

Appointment Scheduling: Your podiatrist will outline a recommended action plan as the best plan for your injury. You will achieve the maximum results when you keep your recommended action plan to this schedule. Therefore, to receive the most out of your care and to save time we ask that you schedule your appointments in advance.

Missed Appointments: Missed appointments will set you back in your recovery, so we ask that wherever possible you keep all your appointments. If an appointment must be changed, 24 hours notice is appreciated. If less than 24 hours notice is given for a cancellation, a cancellation fee may be charged. Consideration will be given for unavoidable circumstances.

All missed appointments must be made up later in the same day or within 24 hours to avoid a cancellation fee. **This fee is not covered by compensable bodies and must be paid by the patient**. People who repeatedly miss or reschedule appointments will regretfully be discharged from care as we realise you will not reach your health goals and we do not wish to waste your time.

I have read and fully understand the above Policy Form

Patient Name (print) _____
(Guardian name if patient is under 18years)

Patient Signature _____
(Guardian signature if patient is under 18years)

Practitioner's Signature:_____ Date_____