



# MALVERN PODIATRY

2C Gordon Grove  
Malvern VIC 3144  
Phone : (03) 9509 1788  
Fax : (03) 9509 1780

## New Patient Information Form

<b>Your Name</b>	Title – eg Mr, Mrs, Ms, Miss, Master	<input type="text"/>
	Surname or family name	<input type="text"/>
	Given name[s]	<input type="text"/>

<b>Your Address</b>	House / Unit / Street Number	<input type="text"/>
	Street	<input type="text"/>
	Suburb	<input type="text"/>
	Postcode	<input type="text"/>

<b>Your Contact Information</b>	Home Phone	<input type="text"/>
	Mobile	<input type="text"/>
	Work Phone	<input type="text"/>
	Email	<input type="text"/>

<b>Your Doctor</b>	Doctors's Name	<input type="text"/>
	House / Unit / Street Number	<input type="text"/>
	Street	<input type="text"/>
	Suburb	<input type="text"/>
	Postcode	<input type="text"/>
	Contact Phone	<input type="text"/>

### Insurance

**Do you have a Pension Health Card?**      NO       YES  if YES then complete below

Pension Card Number

**Do you have Private Health Cover?**      NO       YES  if YES then complete below

Fund Name

**Do you have a DVA Gold Card?**      NO       YES  if YES then complete below

DVA Card Number

Please turn over

## General Information

How did you hear about our clinic?

- Yellow Pages       Advertisement       Referred by a friend       Website

Health Professional / Other (please specify)

## About You

Date of Birth  /  /

Height  cm **OR**  foot  inches

Shoe Size

Are you receiving or have you received medical treatment for any of the following?

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Leg ulcers             |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Heart ailments      | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Ingrown toenail        |
| <input type="checkbox"/> Kidney disease   | <input type="checkbox"/> Excessive bleeding  | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Any infectious disease |
| <input type="checkbox"/> Tinea            | <input type="checkbox"/> Warts               | <input type="checkbox"/> Leg cramps at night | <input type="checkbox"/> Other                  |

If Other, please supply further details

Do you smoke?      **NO**       **YES**

Do you have any ALLERGIES?      **NO**       **YES**  if YES then please specify below

I have made this appointment about my feet because...

## DECLARATION

I believe that the information I have given above is accurate. I accept the conditions of treatment.

Signature of patient / guardian

/  /

Date

## CONDITIONS OF TREATMENT

Payment is required on the day of consultation. Should payment not made on the day I acknowledge I will pay all additional account fees and charges that may be incurred until account is paid in full. A parent or an adult guardian must always accompany and sign for a child or any children under the age of 16. \*HICAPS is not always available as the transaction requires magnetic strip on card to be functioning. (keying in card number is not permitted.) Pension Health Card, DVA Gold Card or Private Health Fund Card are required to be presented on each visit.