PODIATRY REGISTRATION FORM

DATE: _____

FULL NAME: _____

DATE OF BIRTH: _____ / _____ / _____

ADDRESS: _____

SUBURB: _____ STATE: _____ POSTCODE: _____

MEDICARE NO: __ __ __ __ __ __ __ __ __ __ __ REF NO:_____ EXPIRY: _____ / _____

CONCESSION: ☐ HEALTH CARE CARD ☐ PENSION

CARD NO: _____ EXPIRY: _____ / _____

PRIVATE HEALTH INSURANCE: Y / N FUND NAME: _____

CONTACT DETAILS:

HOME: _____ WORK: _____ MOBILE: _____

EMAIL: _____

EMERGENCY CONTACT:

NAME: _____ PH NO: _____

RELATIONSHIP: _____

REFERRING GP:

NAME: _____

PRACTICE: _____

MEDICAL HISTORY:

OCCUPATION: _____

MEDICAL CONDITIONS: _____

SURGICAL HISTORY: _____

MEDICATIONS: _____

ALLERGIES: _____

HOW DID YOU HEAR ABOUT SOLE FOCUS? _____

PRIVACY AND INFORMATION CONSENT FORM

NAME OF PATIENT: _____

DOB OF PATIENT: _____

The Privacy Laws give you certain rights in relation to the information that you provide to this practice. We need your consent to collect information about you. Attending the practice implies that you consent to us knowing about your health situation, either for a particular problem or generally. Our detailed Privacy Policy is provided with this package – please read the information carefully before signing this form which will be kept on file – you may examine it or change it at any time.
The primary reason we collect information is to assess and treat your medical problems properly and to be pro-active in your healthcare. Unless specifically directed otherwise we will, where we deem it to be appropriate, provide relevant information to other health workers directly involved in your medical care – this would include specialist referrals and at the request of a hospital where you are receiving treatment and they require information (such as medication you are taking).
As detailed in the Privacy Policy, information will not be provided to any party for secondary purposes without your written consent.

I have read and understood the PRIVACY POLICY supplied with these forms:

_____
(signed by patient or guardian)

PATIENT ACKNOWLEDGEMENT
I have read this form and understand why collecting information about me is necessary. I am also aware that this practice has a privacy policy on handling patient information.
I understand that failure to provide the practice with all the information it needs may restrict its ability to provide the quality of health care that I want. I am aware that I have the right to access the information collected about me under the conditions detailed in the Privacy Policy.
I consent to the handling of my information by this practice for the primary purposes set out in the Privacy Policy subject to any limitations on access or disclosure about which I notify the practice now or at any time in the future. I understand that if my information is to be used for any secondary purpose my further consent will be obtained.
I acknowledge that I have read this form before signing it and that a member of the practice staff has clarified any aspects of it that I did not at first understand.

I understand that SOLE FOCUS requests 24 hours notice for all cancellations. Cancellations without notice or failure to attend appointments may result in a fee. I also understand that payments in full are required on the same day as your consultation.

PATIENT OVER 16 - Signed: _____ **Date**: _____

Parent/Guardian Name (if under 16 years old): _____

Parent/Guardian Signed: _____ **Date**: _____