THE GOLD COAST
FOOT & ANKLE
SPECIALIST CLINIC

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**Please complete the following form and return to Reception**

((MR / MRS / MS / MISS / DR) SURNAME: ……..

First Name ……. Middle name ……..

PREFERRED NAME…….. DOB ……/……/……. Age……..

Occupation: …… REFERRING DOCTOR: ……

**If Child:** Parent/Guardian Full Name……..

ADDRESS : ……

…… POST CODE ……

TEL NO. (Home) ……. ……(Work) ……..……

(Mobile) ……..……(Email)……...

Next of Kin name and contact number ……..

MEDICARE No: ……... REF NO……EXPIRY DATE ……..

PRIVATE HEALTH FUND ……Number……

Are you covered for Private Hospital treatment /admission/operation? YES / NO

Have you held membership > 12 months YES / NO

ARE YOU AN AGE PENSIONER? YES / NO

ARE YOU ELIGIBLE FOR VETERAN'S AFFAIR YES / NO

Dept. of Veterans Affair - File No…… Gold ❑ White ❑

IS THIS CONSULTATION AS A RESULT OF AN INSURANCE THIRD PARTY CLAIM: YES / NO

Policy No……..

ARE YOU A WORKCOVER PATIENT? YES / NO - Claim No…….....

WORKERCOVER OR INSURER DETAILS…….

If you are work patient please fill a separate Workcover patient registration form.

**(Please turn over and fill out 2nd page)**

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1. Please circle and give details of current problem/s:

Right foot Right ankle Left foot Left ankle other……..

Date problem began:……

1.Describe how and where injury occurred…….

…….

2. Allergies: ……

3. Smoking Yes No (if yes how many per day…….)

4. Alcohol Yes No (if yes how many per day……..)

5. Please list **current medications** you are taking: …….....

……

6. Please list all previous operations: …….....

…….....

…….....

7. Other medical problems (i.e. Diabetes, Rheumatoid arthritis, blood clots in legs and lungs, heart problems, lung problems, kidney problems, Stroke, gout, others please specify:

……

8. Any other information: (i.e. significant family history, previous anaesthetic problems, previous operative or postoperative problems - bleeding, DVT , pulmonary embolism , wound healing etc

…….....

…….....

9. Have you seen any other orthopaedic Surgeon/podiatric surgeon for this condition Yes No

If Yes please provide the name and the date seen:…….....

**Privacy Policy -** Your consent is required for this practice to collect/store/your personal and health information. As well as to disclose information to others involved in your health care management, including treating doctors and specialists. Allied health professionals outside this practice, and any medical tests or reports those are relevant to your ongoing treatment. Information regarding billing and debt collection may have to be disclosed without your written authority. I understand that I am responsible for full payment of this consultation and/or procedures. Failure to pay invoices may result in referral to debt collection agency, which may incur extra charges. I understand and consent to all above.

Patient/Guardian Name & Signature…….. Date ……