



NOBLE PARK PODIATRY

1133 Heatherton Rd
Noble Park VIC 3174
Phone : (03) 9547 1666
Fax : (03) 9546 7781

New Patient Information Form

Your Name

Title – eg Mr, Mrs, Ms, Miss, Master

Surname or family name

Given name[s]

Your Address

House / Unit / Street Number

Street

Suburb

Postcode

Your Contact Information

Home Phone

Mobile

Work Phone

Email

Your Doctor

Doctors's Name

House / Unit / Street Number

Street

Suburb

Postcode

Contact Phone

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.