THE GOLD COAST
FOOT & ANKLE
SPECIALIST CLINIC

Dr Aneel Nihal
FRCS (Glas), FRCS (Edin)
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Consultant Orthopaedic Surgeon

Provider No: 290595DH
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PATIENT REGISTRATION & CONSENT

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: Date of Birth:---------/----------/----------- Age-------------

Surname ______________________ First Name ______________________

Middle Name ______________ "Preferred Name": ______________ Male ☐ Female ☐

Your Occupation ____

Height (meters) ______________ Weight (kilo) ______________ BMI (for office use) ______________

If Child - Parent/Guardian Full Name ______________________ Parent Date of Birth ---------/--------/-------

Address ____

____

Postal Address (If different) ______________________ State _____ Postcode _____

Email ____

Ph Home ______________________ Work ______________________

Mobile ______________________ Fax ______________________

Referring Doctor ______________________ Practice name: ______________________

Usual GP (if different from above) ______________ Practice name: ______________________

Next Of Kin/Emergency Contact ______________________ Phone ______________________

Medicare No. ☐☐☐☐ ☐☐☐☐☐ ☐ No. ☐ Valid To /

Private Health Fund Name ______________________ Number ______________________

Are you covered for Private Hospital treatment / admission / operation? Yes ☐ No ☐

Have you held membership for more than 12 months? Yes ☐ No ☐

Are You An Age Pensioner? Yes ☐ No ☐

Are You Eligible for Veteran's Affairs? Yes ☐ No ☐

Dept. of Veterans Affairs - File No: ______________________ Gold ☐ White ☐

Is This Consultation A Result Of An Insurance Third Party Claim? Yes ☐ No ☐ Policy No ______________

Are You A WorkCover Patient? Yes ☐ No ☐ Claim No ______________________

WorkCover or Insurer Details ____

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

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

   Right foot Right ankle Left foot Left ankle

   Date problem began or Date of an injury: ______________________________

   If no injury how the problem began: ______________________________

2. If an Injury describe how and where injury occurred ______________________________

   ____

3. Allergies ______________________________
4. Smoker Yes ☐ No ☐ If yes how many per day______________
5. Alcohol Yes ☐ No ☐ If yes how many per day______________
6. Please list **current medications** you are taking:______________________________

   ____

7. Please list **all previous operations** ______________________________

   ____

8. Other medical problems (i.e. Diabetes, Rheumatoid arthritis, blood clots in legs and lungs, heart problems, lung problems, kidney problems, Stroke, Gout, Significant family history, previous anaesthetic, operative or postoperative problems – or any others please specify:

   ____

9. Please circle only if applicable to you: HIV/AIDS Positive Hepatitis B or C Positive

   On Oral Contraceptive / implant Pregnant

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

    If Yes - Drs Name & 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, work cover Medicare and any disclosure of the medical tests or reports that are relevant to your ongoing treatment. No access to your medical records will be provided to any other unauthorised person or organisation i.e. solicitor, insurance companies etc. without your express written consent. However Information regarding billing, non-payment and debt collection may have to be disclosed without your written authority to either debt collector/ credit rating agency. I understand that I am responsible for full payment of this consultation and/or procedures. Failure to pay invoices may result in referral to a debt collection agency, which may incur extra charges and I agree to this. I understand and consent to all the above. I also give consent for photographs be taken of my foot/ankle and my X-rays, which may be stored in my medical records/ computer and could be used for training, research or clinical teaching purposes.

I have also read and understand the GC Foot & Ankle Specialist Clinic Frequently Asked Questions.

On the gcfootankle.com Website ☐ In the Waiting Room ☐

Patient/Guardian Name & Signature ______________________________ Date ______________