THE GOLD COAST
FOOT & ANKLE
SPECIALIST CLINIC

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PATIENT REGISTRATION & CONSENT FORM

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** (office use only)

Address: _____

_____

Postal Address (if different) _____ State: _____ **Postcode:** _____

Email: _____

PH: Home: _____ **Work:** _____ **Mobile:** _____

Next of Kin/Emergency Contact: _____

Relationship to NOK/Emergency Contact: _____ **Phone:** _____

IF PATIENT UNDER 18

Parent Name: _____ **Relationship:** _____

Parent Medicare Ref No: _____ **Parent DOB:** _____/_____/_____

Referring Doctor: _____ **Practice Name**: _____

Usual GP: _____ **Practice Name:** _____

Medicare No:

											NO.		**Valid To**				

Private Health Fund Name: _____ **Policy Number:** _____

Do you have Hospital Cover Yes ☐ No ☐ **Held membership for more than 12 months Yes** ☐ No ☐

DVA Patients only: DVA File No: _____ **Gold Card** ☐ **White Card** ☐

Work Cover /CTP

Is this a CTP/Third Party Claim? Yes ☐ **No** ☐ **Is this a Work Cover Claim? Yes** ☐ **No** ☐

If you have answered yes to the above , please fill out the separate Work cover/CTP registration form

Please turn over to page No 2

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

Right Foot Right Ankle Left Foot Left Ankle

If an Injury, when and how did it occur? _____

_____

If no injury when and how did the problem begin? _____

2. Allergies: _____

3. Current smoker (Cigarette) Yes ☐ No ☐ How Many per Day? _____

Ex-Smoker (Cigarette) Yes ☐ No ☐ When did you stop? _____

4. Alcohol Yes ☐ No ☐ If yes how many per day? _____

5. Have you ever been treated for mental health issues or are you currently taking medication for mental health issues: Anxiety, Depression, Bipolar, Schizophrenia etc Yes ☐ No ☐

Please list any mental health medications_____

6. Any other current medications_____

7. Please list all previous operations_____

8. Please circle any relevant medical conditions you have had or have: Diabetes Rheumatoid Arthritis Blood Clots in legs and/or lungs Heart Lung/kidney problems Stroke Gout Depression Anxiety Significant family history anaesthetic Operative or Post-operative problems

9. Please circle if applicable: HIV/Aids Hepatitis B or C Positive Oral Contraceptive/Implant Pregnant

10. Have you ever been seen in any public/private orthopaedic surgeon/podiatric surgeon for this condition? Yes ☐ No ☐ If Yes name the Hospital, Doctor and When_____

GC Foot & Ankle Specialist Clinic has a strict no audio or video recording of consultations or examinations, therefore I consent and understand that I will NOT undertake any recording of the consultation – Please tick box if you agree ☐

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 today's consultation fee as a private patient along with any subsequent review appointment fee** (not applicable to Work cover or Third party patients, where payment has already been pre-approved/authorised) and/or any procedures/moon boot, brace etc. 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/video be taken of my foot/ankle and my radiology images, which may be stored in my medical records/ computer and could be used for training, research or clinical teaching purposes.
I consent and understand that during the examination and/or application of splint/brace/plaster or the removal of sutures/pin may result in some discomfort or pain.

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 Name & Signature _____

Guardian name, relationship and signature Date