LIDCOMBE PODIATRY

NEW PATIENT FORM

Thank you for choosing Lidcombe Podiatry for your foot care needs. This forms has been created to help us to provide you with the most appropriate podiatry treatment, specific to you. It will allow us to identify any possible risk factors to your foot and lower limb health. All patient information provided by you is kept strictly confidential.

Surname: _____ **Given Names:** _____

Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Master ☐ Mr **Date of Birth:** DD/MM/YYYY **Age:** _____

Occupation: _____ **Private Health Fund:** _____

Address: _____

Suburb: _____ **Postcode:** _____

Home No: _____ **Mobile No:** _____

Work No: _____ **Email:** _____

Emergency Contact: _____ **Phone:** _____

Preferred Method of Contact: ☐ Home ☐ Work ☐ Mobile ☐ SMS ☐ Email

What is the main reason for your visit? (Please tick)

☐ General Check-up ☐ Nails ☐ Orthotics ☐ Knee pain
☐ Plantar Warts ☐ Corns ☐ Arch pain ☐ Bunions
☐ Ball of Foot pain ☐ Calluses ☐ Ankle pain
☐ Other (please specify): _____

Do you have any health conditions which may affect your feet/lower limbs? (Please tick)

☐ Diabetes ☐ Rheumatoid Arthritis ☐ Multiple Sclerosis
☐ Arthritis ☐ Gout ☐ Heart Conditions
☐ Other (please specify): _____

Are you allergic to any of the following? (Please tick)

☐ Sports Tape ☐ Local Anaesthetic ☐ Betadine ☐ Latex

How did you hear about Lidcombe Podiatry? (Please tick)

☐ Internet ☐ Doctor ☐ Dooleys Club ☐ Dooleys Gym
☐ Word of Mouth (name): _____ ☐ Other (please specify): _____

I certify that the above information is correct and true to my knowledge. I give permission for the podiatrists of Lidcombe Podiatry to perform treatment as is necessary for my foot/lower limb conditions.

Signed: _____ **Date:** _____