

PATIENT REGISTRATION FORM

DR ANDREW BEISCHER

* Please complete all 4 pages *

Patient Details

Surname: _____ Mr / Dr / Mrs / Miss / Ms / Mst

Given Name/s: _____

Date of Birth: _____ Age: _____

Address: _____

Post Code: _____

Telephone: (H) _____ (B) _____ (M) _____

E-Mail Address: _____

Next of Kin

Name: _____

Address: _____

Tel: _____ Relation to Patient: _____

Referring Details

Referred By: _____ Address: _____

Local General Practitioner – if different to referring doctor

Local Doctor: _____ Address: _____

Podiatrist Details

Podiatrist Name: _____ Address: _____

Are you claiming as a: *please tick appropriate box*

Private Patient WorkCover Transport Accident Commission (TAC)

* Please turn Over

Private Health Insurance

Do you have Private Health Cover Yes / No

If Yes, Name of Health Insurance Fund _____

Membership Number _____

WorkCover Details

Employer Name _____

Employer Address _____

Date of Injury _____

Insurance Company _____

Claim Number _____

Transport Accident Commission (TAC) Details

Claim Number _____

Date of Injury _____

Charges

ALL FEES MUST BE PAID AT TIME OF CONSULTATION

(by Visa / MasterCard / EFTPOS / Cheque or Cash)

*Initial Consultation = \$220.00

*Subsequent Consultation = \$160.00

NOTE: TO OBTAIN MAXIMUM MEDICARE REFUND, A REFERRAL TO MR ANDREW BEISCHER IS REQUIRED

Patient Signature: _____

Date: _____

**Please turn over*

GENERAL MEDICAL HISTORY

Occupation _____

Do you smoke? Yes No **If Yes...How much & for how long?** _____

Are you an ex-smoker? Yes No **If Yes...Please give details** _____

Do you drink Alcohol? Yes No **If Yes...How much?** _____

Do you suffer from any of the following? *Please circle the appropriate*

- | | | | |
|-----------------------|---------------------------|----------------------|------------------|
| Anxiety or Depression | Diabetes | Hepatitis | Skin Disorder |
| Asthma | Embolism | HIV / Aids | Strokes |
| Arthritis | Emphysema | Kidney Stones | Transfusions |
| Bleeding Disorder | Gastrointestinal Disorder | Leg Clots | Ulcers |
| Blood Clots | Gout | Pneumonia | Vascular Disease |
| Bronchitis | Heart Attack | Osteoporosis | |
| Cancer | Other Heart Problems | Other Lung Problem | |
| Congenital Disorder | High Blood Pressure | Rheumatoid Arthritis | |

Other Diseases: (Please List)

Do you take any Medications: Yes No **If Yes...What Medications do you take?**

Do you have any ALLERGIES: Yes No **If Yes...Please List?**

Have you had any RELEVANT operations in the past: Yes No

If Yes...What operations have you had

<i>Type of Surgery</i>	<i>Approx Date</i>	<i>Surgeon / Hospital</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT FOOT & ANKLE PROBLEM

Have you suffered an injury? Yes No

When (approximate date)? _____

How? _____

How far can you walk? *Please Tick Appropriate Box*

Unrestricted 4-6 Blocks 1-3 Blocks Less than 1 Block

Do you suffer pain? No Yes

If so how would you rate your pain? *Please Tick Appropriate Box*

None Mild (Occasional) Moderate (Daily) Severe (Almost always present)

Does your foot / ankle problem cause difficulty walking on some surfaces? *Please Tick Appropriate Box*

No difficulty on any surface Some difficulty on uneven surfaces

Severe difficulty on uneven surfaces, stairs, incline, ladders

Are shoes a problem? Yes No

What shoes do you wear because of your foot / ankle problem? *Please Tick Appropriate Box*

No restriction Comfort shoe wear (ie: runners) Custom or modified shoes / brace

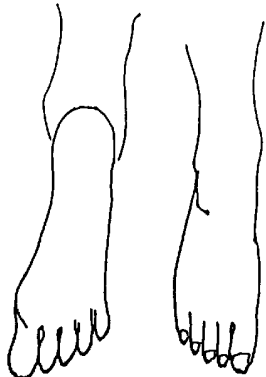
How does the foot / ankle problem limit your activities? *Please Tick Appropriate Box*

No limitation at all No limitation of daily activities but recreational activities are limited

Limited of daily & recreational activities Severe limitation of daily & recreational activities

Indicate the problem areas on the diagrams, if possible

Right



Left

