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

Type of Surgery *Approx Date* *Surgeon / Hospital*

_____

_____

_____

Please turn over

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***