PATIENT REGISTRATION FORM

DR ANDREI CORNOIU

*** 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 = $190.00
*Subsequent Consultation = $140.00

NOTE: TO OBTAIN MAXIMUM MEDICARE REFUND, A REFERRAL TO MR ANDREI CORNOIU 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

<u>Have you suffered an injury</u>? ¡ **Yes** ¡ **No**

When (approximate date)? ______________________________

How? ____

<u>How far can you walk</u>? *Please Tick Appropriate Box*

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

<u>Do you suffer pain</u>? ¡ **No** ¡ **Yes**

<u>If so how would you rate your pain</u>? *Please Tick Appropriate Box*

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

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

¡ **No difficulty on any surface** ¡ **Some difficulty on uneven surfaces**

¡ **Severe difficulty on uneven surfaces, stairs, incline, ladders**

<u>Are shoes a problem</u>? ¡ **Yes** ¡ **No**

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

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

<u>How does the foot / ankle problem limit your activities</u>? *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**

<u>Indicate the problem areas on the diagrams, if possible</u>