Patient Registration/Consent Form

CONTACT

Title: _____ First Name: _____ Surname: _____

Address: _____ Home Phone: _____

_____ Mobile: _____

Postcode: _____ Emergency Contact: _____

Email: _____

GENERAL

Date of Birth: _____

Occupation: _____

Known Allergies: _____

(Adhesive Plasters / Latex gloves etc.)

If under 18 years then consent given by:

Name: _____

Relationship: _____

How did you hear of us? _____

MEDICAL

GP Surgery: _____

Diabetic: _____ If 'YES' then Type: _____

Blood Thinning Medication: _____

Other Medication: _____

_____

NOTES

Any Operations or Medical Conditions? _____

_____

Reason for your visit today?_____

_____

DECLARATION

All information provided is **strictly confidential** and will not be shared with any 3rd parties.

I give permission for my details to be held on the clinic database.
I declare that to the best of my knowledge the information given on this form is correct and that if any of the information should change it is my responsibility to inform the practitioner.
I am happy to receive treatment within Bridge Street Foot Clinic.
PLEASE SEE OUR FULL DATA PROTECTION POLICY WHICH IS ON DISPLAY IN CLINIC RECEPTION AND ALSO AVAILABLE ON OUR WEBSITE. www.bridgestreetfootclinic.co.uk

Sign: _____ Date: _____