

C3 Clinics – Podiatry/Chiropody New Patient Record Form

Cardiff :223 – 225 Pantbach Road, Cardiff CF14 6AE 029 20627888 Bridgend: 7 Gaylard Buildings, Court Road, Bridgend CF311BD 01656 663999

Title: Dr/Mr/Mrs/Miss/Ms Forename: Surname:

Address: Postcode:

Phone: (mobile): Email:

How did you hear about the clinic: Website Friend GP Ref Other.....

Date of Birth: Your Age: Shoe size: What is your occupation?

GP Name and Address:

ABOUT YOU AND YOUR HEALTH:

Please list the medication you are taking:	Do you suffer with any of the following? (please tick the box)			
.....	Diabetes	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>
.....	Heart Problems	<input type="checkbox"/>	Ankle Swelling	<input type="checkbox"/>
.....	Respiratory Problems	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
.....	Neurological Problems	<input type="checkbox"/>	Nut Allergy	<input type="checkbox"/>
.....	Thyroid Disorder	<input type="checkbox"/>	HIV	<input type="checkbox"/>
.....	High Blood Pressure	<input type="checkbox"/>	HEP B/C	<input type="checkbox"/>
.....	Arthritis	<input type="checkbox"/>	Anaemia	<input type="checkbox"/>
.....	Eczema	<input type="checkbox"/>	Circulation Problems	<input type="checkbox"/>

Do you have any allergies (e.g. iodine, Latex, Anaesthetics etc)

Please list any other medical problems (including significant illnesses, surgical procedures, hospital admissions etc) :
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Ladies: are you pregnant? Yes No Do you smoke? Per day Do you drink? Units per week

PATIENT CONSENT SECTION (Mandatory):

The clinic may need to contact your GP or health care professional. Do you give your consent? Yes No

<p>Data Protection and Late Cancellation Policy:</p> <p>I have read the C3 Clinics Data Protection Policy and give my consent to the Clinic to maintain records for the purposes outlined within the policy. I also understand that if I need to cancel or reschedule an appointment I have booked, a minimum of 12 hours' notice is required. If I cancel or reschedule my appointment (or fail to turn up for my appointment) a fee will be payable.</p> <p>Signed: Date:</p>
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<p>Treatment Consent (To be signed by a parent or guardian in case of a minor):</p> <p>I hereby give my consent to treatment.</p> <p>Signed: Date:</p>
