Speight's
PODIATRY
Diabetes Specialist

# REGISTRATION FORM

DATE _____

TITLE Mr / Miss / Ms / Mrs / Dr / Prof / Sir / Dame / Other

SURNAME _____ FIRST NAME _____

ADDRESS _____

_____

_____

PHONE NUMBERS

Home _____ Work _____ Mobile _____

DATE OF BIRTH _____ OCCUPATION _____

GP _____ ACC NUMBER _____

SPORT OR PHYSICAL ACTIVITY (please note approx hrs per week)

_____

HOW DID YOU FIRST HEAR ABOUT SPEIGHT'S?

☐ Google ☐ Facebook ☐ Word of Mouth ☐ Speight's website ☐ Other

MEDICAL HISTORY

Have you had any of the following (please tick ☐)

☐ Heart condition ☐ Diabetes ☐ Asthma ☐ Hepatitis
☐ Heart surgery ☐ Kidney disease ☐ Epilepsy ☐ High blood pressure
☐ HIV

Other _____

Allergies (name) _____

Current Medication _____

Reason for this visit _____

CHILD PATIENT INFORMATION (please complete if patient is under 16 years old)

Name of parent or guardian _____

CONSENT TO RECEIVE E-MAILS

Do you wish to receive offers via Email or Social Media from time to time? ☐ Yes ☐ No

If yes, e-mail address _____

CONSENT TO TREATMENT:

I consent to podiatry treatment, and understand that a full verbal and written explanation will be given at the time it is given and that I have the right to decline part or all of it at any time. I also understand that when invasive treatment (such as the breaking of the skin) occurs, infection may result in spite of all reasonable precautions being taken, and that this could require further medical care, possibly from other health professionals. I undertake to pay treatment charges and cost of materials for any treatments declined by third party payers.

Signature _____ Date _____

** If under 16 years old, the name of a parent or guardian is required.*

Name _____ Signature _____ Date _____

Relationship to the patient _____