DR BRIAN MARTIN
PATIENT REGISTRATION FORM

Please complete the form and bring it to your appointment with Dr B. Martin or email to admin@drbrianmartin.com.au

❑ Mr.❑ Mrs.❑ Miss ❑ Ms. ❑Master

First name:	Last name:	Birth date: / /	Age:
Home Phone:	Mobile phone no:	□ Opt out of SMS appointment reminders	
Email:			
Street Address:			
P.O. Box:	Suburb:	State:	Post Code:
Occupation:	Treatment area: eg Right /Left Toe/Foot/Ankle	Height:	Weight:
Next of Kin:	Relationship:	Phone	
Referring Doctor: (name, address + Ph)			
General Practitioner: (name, address + Ph)			
Treating Physiotherapist or Podiatrist: (name, address + Ph)			

Medicare No:		Ref No:	Exp date:	
Private Health Insurance:		No:		
Pension Type:		No:		
Veterans No:				
Are you making a claim for Compensation? Yes / No		Date of Injury:		
□ Workers Compensation	□ CTP	□ Personal Injury Claim	□ Public Liability	□ Sports Insurance
Claim Number:		Insurer:		
Case Manager Name Rehab Provider:			Phone Contact	
Insurers postal address: Insurers email:				

Image type eg. Xray, Ct, MRI, bone scan	**Radiology Company and location:** eg.. Castlereagh, Norwest imaging, SAN Radiology	***Date taken***	**Patient ID** number if known

Declaration:
I give permission for correspondence to be sent to my referring doctor, general practitioner, physiotherapist and insurance company where appropriate.
I undertake to pay all fees owing to my Surgeon, including in the event that liability is denied or any outstanding accounts that have not been paid in full by my insurer.
I also understand that any outstanding monies requiring debt recovery will incur Debt Recovery fees and I will also be responsible for any legal cost incurred

Patient/Guardian signature	*Date*
Name (please print):	

Please circle Yes or No if you have or have had any of the below:

Cancer	Y/N	Difficulties with Anaesthetic	Y/N
Diabetes	Y/N	Arthritis	Y/N
Kidney Disease	Y/N	AIDS	Y/N
Asthma	Y/N	Hepatitis	Y/N
Emphysema	Y/N	Herpes	Y/N
Any other lung problems	Y/N	Sleep Apnoea	Y/N
High Blood Pressure	Y/N	Thyroid Disease	Y/N
Heart Conditions	Y/N	Bleeding disorders	Y/N
Epilepsy	Y/N	Stomach Ulcer	Y/N
Stroke	Y/N	Hormonal Treatment:	Y/N
Deep Vein Thrombosis	Y/N	Female contraceptive	Y/N
Varicose Veins	Y/N	Sensitive to tapes, jewellery, metals	Y/N
Depression/anxiety	Y/N	Panic Attacks	Y/N
Do you smoke? How many per day?	Y/N	Do you drink alcohol? How many per day?	Y/N

Explain in further detail any of the above:
What are your living arrangements? Do you live alone? Stairs?
Are you allergic to anything? What reaction did you experience?

PREVIOUS SURGERY: or provide a separate attached list

Year	Operation:	Doctor:	Hospital

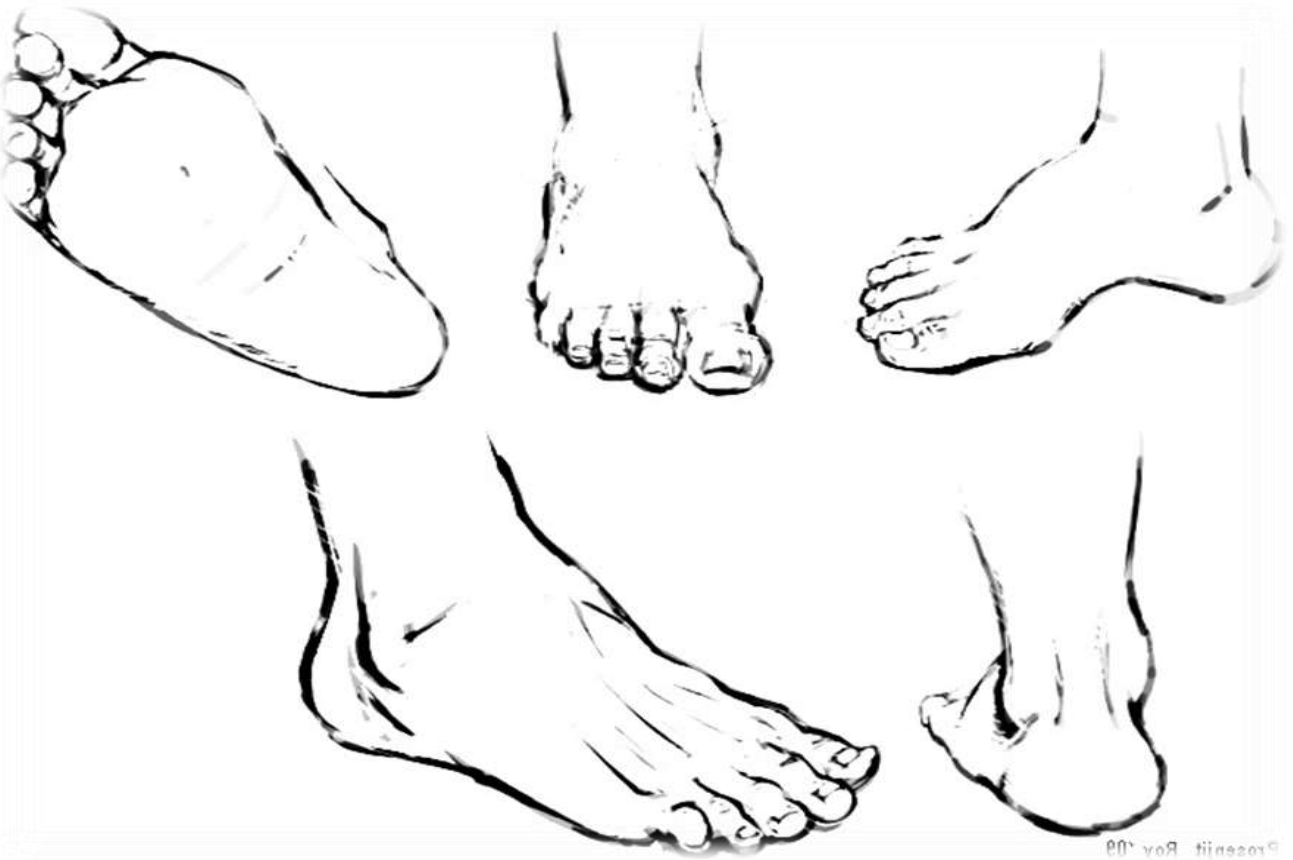
CURRENT MEDICATIONS: please provide a detailed list if more space is required

Name	Dose per day	For what condition	Treating doctor

PAIN REFERENCE

How would you describe your pain?	
How severe is your pain?(0=no pain,10=severe pain)	
What makes your pain worse?	
What makes your pain better?	
What medications do you take for the pain?	
How far/long can you walk?	
How long can you stand?	
Do you have trouble with? • Stairs? • Slopes? • Squatting? • Running?	 Y/N Y/N Y/N Y/N
Have you had any treatment such as? • Physiotherapy • Orthotics • Injections • Surgery • Boot/brace	 Y/N Y/N Y/N Y/N Y/N

Please mark the area of concern on the pictured **RIGHT FOOT:**



Please mark the area of concern on the pictured **LEFT FOOT:**