PATIENT REGISTRATION FORM

Surname:		Date of Birth:	
First Name:		GP:	
Address:		GP Address:	
Telephone: home mobile		Current Foot Complaint:	
Email:			
Occupation:			

Medical History:		Medication:	
Allergies:			
Consent declaration		Consent for SMS reminder: Y/N	Consent to contact GP: Y / N

All information will be kept confidential and is for the sole purpose of treatment at The Foot Retreat Podiatry. Information will not be shared with any third parties without consent. I have seen and read the data protection policy.

I give consent to be treated by the podiatrist at The Foot Retreat.

I confirm that I am aware that Podiatrists may use sharp medical instruments and will formulate a treatment plan to help manage my foot condition Date:_____

Signed _____ Name (PRINT) _____