PODIATRY CARE GAWLER
MOVE WELL. LIVE BETTER.
FOOT • ANKLE • ORTHOTICS

PATIENT INFORMATION

DO YOU HAVE PRIVATE HEALTH INSURANCE? Company: _____ YES / NO	ARE YOU SEEING US WITH A DVA REFERRAL? (DEPARTMENT OF VETERANS AFFAIRS) YES / NO	DO YOU HAVE A MEDICARE CARE PLAN FROM YOUR GP? YES / NO	ARE YOU SEEING US AS A WORKCOVER CLAIM? YES / NO

TITLE:	FIRST NAME/S:	SURNAME:	DATE OF BIRTH:
ADDRESS:			POSTCODE:
MOBILE:		HOME PHONE:	GENDER:
EMAIL ADDRESS: (important for reminders and updates)			OCCUPATION:
NAME OF PARENT/GUARDIAN IF CHILD UNDER 18:		EMERGENCY CONTACT NAME AND NUMBER:	
DO YOU HOLD A PENSIONER/CONSESSION CARD? YES / NO		CRN: __ __ __ - __ __ __ - __ __ __ __ EXPIRY: _____ / _____ /_____	
DEPARTMENT OF VETERANS AFFAIRS – CARD TYPE GOLD / WHITE (If a white card please see receptionist)		NUMBER:	
MEDICARE CARD DETAILS: __ __ __ __ __ __ __ __ __ __ __		Your Ref No: _____ EXPIRY: _____	
NAME AND LOCATION OF GP:			

PLEASE TICK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE:			
	☐ Diabetes ☐ High Blood pressure ☐ Arthritis ☐ Vascular disease ☐ Heart condition ☐ Blood clotting/ DVT ☐ Poor eyesight	☐ Hearing problems ☐ HIV / Hepatitis ☐ Blood abnormalities ☐ Back injury ☐ Knee injury ☐ Hip injury ☐ Epilepsy	☐ Kidney Disease ☐ Liver Disease ☐ Asthma ☐ Poor healing ☐ Skin problems ☐ Poor circulation ☐ High Cholesterol
OTHER MEDICAL CONDITIONS: (Please specify)			
LIST ANY ACTIVE MEDICATIONS:			

PLEASE TURN OVER AND COMPLETE NEXT PAGE

ALLERGIES:
LIST ANY SPORTS YOU UNDERTAKE:

FOOT HISTORY (Please tick):		
☐ Athletes foot/ Tinea ☐ Bunions ☐ Callus / Thick skin ☐ Corns ☐ Difficulty cutting nails ☐ Back pain	☐ Cramps ☐ Discoloured nails ☐ Foot pain ☐ Heel pain ☐ Aching legs ☐ Shin pain	☐ Headaches ☐ Nail problems ☐ Plantar warts ☐ Reduced Sensation ☐ Numbness ☐ Swelling

HOW DID YOU HEAR ABOUT US?		
	☐ Doctor/ Health professional ☐ White / Yellow pages ☐ Signage	☐ Website/ Google ☐ Family/ Friend ☐ Other

Appointment Policy

We realise your time is precious, as is ours. We will try to contact you before your appointment if there are any delays and would like you to contact us if you are delayed so we can efficiently use our time. If you are unable to make your appointment, please phone the clinic as soon as possible. A $20 appointment cancellation fee may apply if 24 hours notice is not given to the clinic. If you are more than 10 minutes late, we may need to reschedule your appointment.

Payment Policy – Pay on the Day

In an effort to reduce costs and minimize any increase in our fees, we operate a "pay on the day" policy. We ask that you pay the full fee for your consultation at reception after you have seen your podiatrist. Our strict policy is full payment by cash, cheque, credit card, eftpos, or HICAPS at the time of completion of treatment. DVA card holders will be billed to DVA. Workcover and NDIS will be billed to the assigned insurers or agencies with prior approval. You will be notified of any changes within our practice or any advances which ultimately affect you and your family's health. We respect your right to privacy and personal details will always remain private and confidential to this practice.

Medicare Gap

Medicare Payments are to be made on the day. Non concession Medicare consult will cost $95.00 with a rebate of $61.80, concession card holders will cost $85.00 with the rebate of $61.80. Rebates can be completed by us either straight back into your Eftpos account or lodged with Medicare on your behalf to whatever account you have registered with Medicare.

Patient Consent to Release Information

All patient information is considered confidential and used solely for the purpose of providing the best care, to get you moving and feeling better. Podiatry Care Gawler may have to contact some (or all) of the following people to allow successful injury recovery and payment of accounts.

Physician, Specialist, Insurance company	WorkCover and Employer (forWorkCover claims only)	Medical Imaging (xray reports)	Insurance adjuster and/or Lawyer (MVA claims only)

I agree to let Podiatry Care Gawler communicate as needed with individuals indicated above regarding my care and payment of account. I understand and accept the above policies. I hereby agree to pay all debt collection costs, in the event that my/our account falls overdue and is placed in the hands of a debt collection agency.

Name: _____ Signed: _____ Date: _____

Thank you for completing this sheet, please hand it back to the Receptionist.

This information will be kept private and confidential and help us to formulate the best treatment for you

Updated July 2026