Tel: 533-2508
Email: info@atlanticpodiatry.bm
www.atlanticpodiatry.bm

WELCOME TO ATLANTIC PODIATRY

New Patient Information & Consent Form

Personal Details

Full name of patient: _____

Mailing Address: _____

Physical address, if different: _____

Mobile Number: _____ Home: _____ Work: _____

Email Address: _____

Date of birth: Day_____ Month _____ Year _____ Sex: M F

Employer: _____

Insurance Details

Provider: _____ Group number: _____

Certificate: _____ Effective Date: _____

Primary insured, if not patient: _____

Relationship to primary insured: Self Spouse Child

Employer of primary insured: _____

Address of primary insured: _____

Phone number of primary insured: _____

Emergency Contact

Name: _____ Relationship to client: _____

Phone number(s): _____

General Practitioner Details

Name of Practitioner: _____ Clinic Name: _____

Do you consent that we communicate with your GP about your condition if necessary: Yes / No

Are you under other physical care? Yes / No

If yes, name and profession of practitioner: _____

Reason for your visit

What is the main reason for your visit: _____

When did this begin: _____

How did this begin: _____

Has this occurred before: Yes / No When: _____ Is it: Getting worse / Staying the same / Improving

How did you become aware of our clinic: _____

Medical & Foot Health History

Please tick (✔) next to any condition you presently have. Please cross (X) next to any condition you have previously had

Ankle Injury	Circulatory Problems	Heel Pain	Knee Pain	Rheumatoid Arthritis
Ankle Pain	Corns/Callous	High blood pressure	Liver Disease	Skin Conditions
Arch Pain	Cramps in legs	High Cholesterol	Neuropathy	Swelling in the feet
Arthritis	Diabetes	Hip Pain	Numbness in the feet	Tired/Aching Feet
Bleeding Disorder	Flat feet	H.I.V/ AIDS	Plantar Fasciitis	Leg/ Foot Ulcers
Blood Clot	Fungal Nail Infection	Itching/Rash on feet	Pregnancy	Varicose Veins
Bunions	Gout	Kidney Disease	Sciatica	Walking Problems
Cancer	Healing Issues	In-grown Toenail	Shin Splints	Warts

Other (Please Specify): _____

Do you have any allergies or have you had any reactions to adhesive tape, latex, iodine, local anaesthetic, or antibiotics?

Details: _____

Current medications (including blood thinners): _____

Have you ever been to a Podiatrist? Yes / No

If yes, when/where was your last visit: _____

SMS/Text Messaging Consent (Optional)

[ ] I agree to receive recurring SMS/text messages from Atlantic Podiatry Ltd. at the mobile number provided above about appointment confirmations and reminders, scheduling or rescheduling, responses to enquiries, requested follow-up, and other patient-service communications. Message frequency varies. Message and data rates may apply. Reply STOP to opt out or HELP for assistance. Consent is not a condition of receiving treatment.

Atlantic Podiatry does not sell, rent, or share mobile numbers or SMS consent information with third parties, affiliates, or lead generators for marketing/promotional purposes.

Privacy Policy: www.atlanticpodiatry.bm/privacy-policy | SMS Terms: www.atlanticpodiatry.bm/sms-terms

Consent to Care

I consent to Atlantic Podiatry Ltd. providing podiatric assessment and treatment to me, or to the patient for whom I am legally authorised to act.

Insurance Authorisation and Assignment of Benefits

I authorise Atlantic Podiatry Ltd. to disclose to my insurer and/or claims administrator personal and clinical information reasonably necessary to verify coverage, submit and process claims, obtain payment, and administer my insurance benefits. I authorise payment of applicable insurance benefits directly to Atlantic Podiatry Ltd. I understand that I remain responsible for charges not covered by my insurer, subject to the terms of my insurance plan and applicable agreements.

Privacy Notice

Atlantic Podiatry Ltd. collects and uses personal and health information to provide care, manage appointments, communicate with patients, process billing and insurance claims, and meet applicable legal and professional obligations. Our full Privacy Policy, including information about your rights under PIPA and how to contact our Privacy Officer, is available at www.atlanticpodiatry.bm/privacy-policy. A copy is available from the clinic on request.

_____

Signature of Patient / Guardian / Authorised Representative

Name (print): _____ **Date:** _____

If signing for the patient, relationship / legal authority: _____