PLEASE, tell us how you heard about our clinic

Ad (name)?, doctor referral?, Signage? Friend? Family?

☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Other:** ____________

First Name: ____________________ (please no nick names) **Last** Name: ____________________ **Date:** __________

Address: ______________________________ **City:** ______________ **Postal:** __________

Age: _____ **Sex:** _____ **Weight:** _____ lbs **D.O.B:** ____________ (Day - Month - Year) **Home#:** ______________

E-mail: ______________________________ **Work#:** ______________

Family Dr: ______________ **Dr. Tel:** ______________ **Cell#:** ______________

Insurance Co.: ______________ **Primary Holder:** ______________ **Employer:** ______________

Current Complaint:

☐ Athlete's Foot
☐ Diabetic Foot Care
☐ Thick Nails
☐ Other: ______________________
☐ Callous
☐ Corns
☐ Warts
☐ Fungal Infection
☐ In-Grown Nails
☐ Painful Feet
☐ Orthotics / Shoes

Medical Allergies:

____
____
____

Medical History: *Check off any of the following applicable to you*

☐ **Good General Health**

Cardiac
☐ Hypertension
☐ Peripheral Vascular Disease
☐ Angina
☐ Myocardial Infarction
☐ Cerebral Vascular Accident
☐ Congestive Heart Failure
☐ Other Heart Problems
☐ Blood Disorders (e.g.: HIV, Hepatitis)

Psychological ______________________

Respiratory
☐ Asthma
☐ Bronchitis

Endocrine
☐ Thyroidism
☐ Diabetes (Type I) yrs: ______
☐ Diabetes (Type II) yrs: ______
☐ Osteoporosis

Dermatology
☐ Psoriasis
☐ Fungal
☐ Other ______________

Musculoskeletal
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Gout
☐ Back Condition ______________
☐ Neuromuscular Disorder ______________

Fractures ______________________

Other ______________________

Medication Name	Taken for	Medication Name	Taken for

ALL - Past Surgeries	Year

West Toronto Foot & Ankle Clinic Consent Form for Collection, Use and Disclosure of Personal Information and Treatment

Here is a summary of our privacy policies, which outline what our office is doing to ensure that:
-only necessary information is collected about you;
-we only share your information with your consent;
-storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
-our privacy protocols comply with legislation, standards of our regulatory body, the College of Chiropodists of Ontario, and the law.

Summary of Uses, Collection and Disclosure of Personal Information

-to deliver safe and efficient patient care
-to identify and to ensure continuous high quality of service
-to assess your healthcare needs
-to provide health care
-to advise you of treatment options
-to enable us to contact you
-to establish and maintain communication with you
-to offer and provide treatment, care and services in relationship to chiropody care generally
-to advise you of special events or opportunities
-to advise you that a product or service should be reviewed
-to communicate with other treating health care providers, including specialists and referring health care practitioner e.g. family doctor
-to allow us to maintain communication and contact with you to book and confirm appointments
-to allow us to efficiently follow up for treatment, care and billing
-for teaching, research, demonstration purposes on an anonymous basis
-to perform Chiropody care in best practice protocols
-to complete and submit chiropody claims for third-party adjudication and payment
-to comply with the legal and regulatory requirements of the College of Chiropodist of Ontario, according to the provisions of the Regulated Health Professions Act by MoHLTC
-to permit potential purchasers, practice brokers or advisors to evaluate and conduct an audit in preparation for the sale of the chiropody practice
-if applicable to deliver your charts and records to the chiropodist′s insurance to enable the insurance company to assess liability and quantify damages
-to prepare material for the Health Professions Appeal and Review Board (HPARB)
-to invoice for goods and services
-to process credit card payments
-to collect unpaid accounts
-to assist this office to comply with all regulatory requirements
-to comply generally with the law

Our organization, the West Toronto Foot & Ankle Clinic Inc., includes chiropodists, chiropody students and support staff. We are aware of the sensitive nature of the information that you have disclosed to us. At the West Toronto Foot & Ankle Clinic, we are all trained in the appropriate uses and protection of your information. We use a number of consultants and agencies that may, in the course of their duties, have limited access to personal information we hold. These include computer consultants, office security, maintenance and cleaners, bookkeepers and accountants, temporary workers to cover holidays/sick days, credit card companies, website managers and lawyers. We restrict their access to any personal information we hold as much as is reasonably possible. We also have their assurance that they follow appropriate privacy principles and will not disclose any of your information.

By signing the West Toronto Foot & Ankle Clinic Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

I acknowledge that it is my responsibility to be aware of any insurance coverage restrictions and it is not the obligation of the West Toronto Foot & Ankle Clinic to resolve any insurance claim issues on my behalf.
You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

I understand that to provide me with Chiropody goods and services, the West Toronto Foot & Ankle Clinic Inc. will collect some personal information about me. I agree to, the West Toronto Foot & Ankle Clinic collecting, using and disclosing personal information about me as set out above and in the West Toronto Foot & Ankle Clinic's Privacy Policy.

I understand and agree to the posted fee structure and hereby authorize the Chiropodist in charge to perform treatment on myself as explained to me by the Chiropodist both surgical and non-surgical which may include anesthetic injections.

Signature: ____________________________ Printed name: ____

Date: ___________________________ Name/Signature of Witness____________________________________