JUNCTION
Foot & Ankle Group

Appointment Date: .....

New Patient Information Form

Personal details

Title: Mr Mrs Ms Miss Master

Date of birth: .....

First Name: .....

Last Name: .....

Address: .....

Suburb: .....

Postcode: .....

Telephone: Home: .....

Mobile: .....

Work: .....

Email address: .....

Health Insurance Fund: .....

Membership No: .....

Medicare No: .....

Exp: .....

Ref No: .....

DVA No: .....

Gold: ☐ White card: ☐

Occupation: .....

Your Doctor: .....

Doctor's Suburb: .....

Do you agree to a courtesy letter being sent to your GP/medical specialist about your visit here? ☐ Yes ☐ No

Are you attending under a Workers Compensation Claim? ☐ Yes ☐ No To claim we require written approval for funding.

Claim No: .....

Case Manager: .....

Are you an NDIS participant? ☐ Yes ☐ No

We accept self-managed and plan-managed NDIS participants.

NDIS No: .....

Plan Manager: .....

Next of Kin/Emergency Contact

Name: .....

Phone: .....

Relationship: .....

Reason for this visit

My complaint is: .....

How long have you had this complaint? ..... Days ..... Months ..... Years

Please tell us who referred you to this clinic or how you found out about us: .....

Medical History

Have you ever had any of the following? (PLEASE ✓ TICK IF YES)

☐ Asthma	☐ Blood pressure problems	☐ Heart disease	☐ Anaemia	☐ Allergies
☐ Diabetes	☐ Blood clotting problems	☐ Hepatitis	☐ Stroke	☐ Epilepsy
☐ Circulatory disorders	☐ Blood borne viruses	☐ Kidney disease	☐ Gout	☐ Skin conditions
☐ Osteoarthritis	☐ Rheumatoid artthritis	☐ Slow/poor healing	☐ Foot/Leg Injuries	☐ DVT/PE
☐ Surgical procedures	☐ Poor vision/hearing problems			

Other problems: .....

Medications: .....

Do you smoke or vape? ..... If yes, quantity: .....

I declare the above information is true (if under 16 years of age, please provide details of guardian)

Name: ..... Signature: ..... Date: .....

Please turn over for consent and payment of fees details

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Consent to Collect, Use, and Release Medical Information

We require your consent to collect, use, and disclose personal health information to provide you with safe, efficient healthcare. Please read this information carefully and sign where indicated below.

Our clinic uses an advanced digital tool to assist with clinical documentation. This tool allows our podiatrists to accurately capture the details of your consultation and allows our podiatrists to focus more attention on you, rather than on extensive note-taking, ensuring a more engaged and thorough consultation. Please be assured that your privacy is our utmost priority. All information is handled securely, is not stored, and is permanently deleted once the clinical documentation for your visit is complete. We ask for your consent to use this tool to enhance the quality of your care.

I give my consent for my podiatrist to collect, use and disclose my personal information as required by the Privacy Act 1988 and my consent to collect, use, transfer and store clinical images for the purposes of my clinical care and education (including x-rays, intra-operative and clinical images or photos). I also consent to the use of a digital dictation tool during my consultation.

This medical practice collects information for the primary purpose of providing quality healthcare. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your healthcare needs. This means we will use the information you provide in the following ways:

1. Communications regarding diagnosis, treatments, and recommended preventative healthcare services.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Collect from and disclosure to others involved in your healthcare, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the healthcare and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I may notify this practice.

Name: ..... Signature: ..... Date: .....

Telephone: ..... If under 16 years of age, please provide details of guardian

Person responsible for payment of fees

Name: ..... Signature: ..... Date: .....

Telephone: ..... If under 16 years of age, please provide details of guardian