ASHBURNHAM FOOT & ANKLE CENTRE

PATIENT INFORMAITON FROM

Welcome to our clinic! Please help us get to know you better by providing the following information.

Name (first and last): _____

Address: _____ **City:**_____ **Postal Code:**_____

Date of Birth (dd/mm/yy):_____

Phone Number: Home_____ Cell_____ Other_____

Email Address: _____

Preferred Method of Appointment Reminder (circle one): **Phone, Email** or **Text**

Occupation: _____ **Employer:** _____

Do you have extended health benefits? YES / NO
If "Yes", please list: ***Company:*** _____ ***Policy/Cert.#:*** _____

Emergency Contact: _____ **Relationship:**_____
Phone Number: _____

Family Physician:_____ **Phone Number:**_____
City: _____

How did you hear about our clinic? (please check on or explain)

- o **Physician/Practitioner Referral**
- o **Google**
- o **Yellow Pages**
- o **Flyer/Newspaper**
- o **Family/Friend**
- o **Other:**
- o **Social Media**
- o **Location/Walk-by/Signage**
- o **Clinic Website**
- o **Informational Session**
- o **Newsletters**

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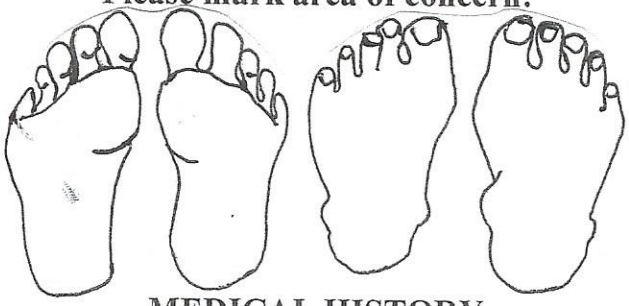
REASON FOR VISIT

Describe the foot problem you are experiencing:

_____

_____

Please mark area of concern:



MEDICAL HISTORY

Please check all that apply (please specify if needed)

- ○ Diabetes (Type: 1 or 2)
- ○ Osteoarthritis
- ○ Rheumatoid Arthritis
- ○ Psoriatic Arthritis
- ○ Liver Disease
- ○ Kidney Disease
- ○ Hypertension (High BP)
- ○ Hypotension (Low BP)
- ○ High Cholesterol
- ○ Stroke _____
- ○ Heart Attack _____
- ○ Angina
- ○ HIV/AIDS
- ○ Hepatitis _____
- ○ Asthma
- ○ Thyroid Disease
- ○ Lung Disease _____
- ○ Acid Reflux
- ○ Bleeding Disorder _____
- ○ Nerve Disorder
- ○ Pregnant or Breastfeeding
- ○ Bone / Osteoporosis / Osteopenia
- ○ Skin Condition _____
- ○ Circulatory Disorder: _____
- ○ Tuberculosis

Other medical conditions not listed above: _____

Allergies: _____

Surgery, Fractures and/or implants: _____

Smoking History (yes – how long, how much, how often) _____

Alcohol History (yes – how long, how much, how often) _____

Height: _____ **Weight:** _____ **Shoe Size:** _____ **Shoe Type:** _____

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CURRENT MEDICATIONS

Please list current medications you are taking and reason for use if known:

_____ _____ _____

_____ _____ _____

_____ _____ _____

If medications are unknown our clinic can contact your pharmacy for a list. If you would like us to do so, please fill in the information below.

I give consent to the Ashburnham Foot and Ankle Centre to contact my pharmacy to release a list of my current medications.

Sign: _____ ***Pharmacy name and location:*** _____

FEE SCHEDULE AND CONSENT

Foot care services in Ontario are **NOT** covered under OHIP. However, most **Third Party Insurance and Extended Health Care Plans** do cover services provided by a foot specialist / Chiropodist. Your visits may also be eligible for income tax health deduction purposes.

Fee Schedule:
Ashburnham Foot and Ankle Centre's fee schedule is based on the Ontario Society of Chiropodist of the Canadian Federation of Podiatric Medicine's recommendations. ***Prices may change on an annual basis. Notifications will be made if there is a change in the fee schedule.***

Appointment Cancellations:
We understand appointments may need to be cancelled. We appreciate you working with us and giving us 24 hours notification. Appointments not cancelled within 24 hours may be subject to a visit fee ($55).

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS PAID DIRECTLY TO THE PHYSICIAN (If applicable). I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE ASHBURNHAM FOOT AND ANKLE CENTRE OR MY INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS. I CONSENT FOR TREATMENT AND ANY ADDITIONAL TREATMENT TO BE PERFORMED BY ASHBURNHAM FOOT AND ANKLE CENTRE. AS A GUARDIAN YOU ARE DECLAERING TO BE THE GUARDIAN OF THE PATIENT.

ALL PESONAL AND HEALTH INFORMATION IS KEPT CONFIDENTIAL.

Signature of Patient or Guardian: _____ **Date:** _____