KAWARTHA FOOT ORTHOTIC CLINIC

PATIENT INFORMATION FORM

Welcome to our clinic! At Kawartha Foot & Orthotic Clinic, we are dedicated to providing exceptional foot care solutions for individuals of all ages. Please help us get to know you better by providing the following information.

First Name: _____ **Last Name**: _____

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*** or ***Email***

Occupation: _____ **Employer:** _____

Insurance Provider (if applicable): _____ **Policy Number #:** _____

Member ID#: _____ **Benefit Type:** _____

Emergency Contact: _____ **Relationship:** _____

Phone Number: _____

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

Address: _____ **Fax Number:** _____

How did you hear about our clinic? (Please check one or explain)

- ○ Physician / Practitioner Referral
- ○ TV Advertisement
- ○ Google
- ○ RateMDs
- ○ Yellow Pages
- ○ Flyer
- ○ Newspaper
- ○ Family/Friend
- ○ Facebook
- ○ Location/Walk-By/Signage
- ○ Clinic Website
- ○ Radio Advertisement
- ○ Instagram
- ○ Yelp
- ○ Informational Session
- ○ Newsletters

Other *(Please Explain):*

_____

_____

Family, Friend or Colleague *(Provide Name):*

_____

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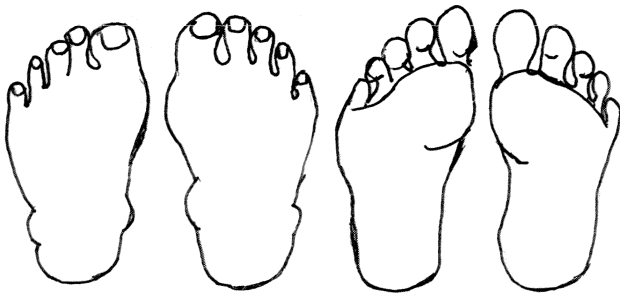
REASON FOR VISIT

Describe the foot problem you are experiencing:

_____

_____

Please mark area of concern:



MEDICAL HISTORY

Please check all that apply?

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

Other medical conditions not listed above:

_____

Allergies (Drugs, Food, Environment, etc.):

_____

Major surgery, fractures and/or implants:

_____

Smoking History (IF yes - how long, how much and how often) _____

Alcohol History (IF yes - how long, how much and how often) _____

Height: _____ **Weight:** _____ **Commonly Used Shoes:** _____ **Size:** _____

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Current Medications

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

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU ON BLOOD THINNING MEDICATION? YES / NO

FEE SCHEDULE AND CONSENT

Foot care services in Ontario are **NOT** covered by OHIP. However, most **Third Party Insurance & 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:
Kawartha Foot & Orthotic Clinic's fee schedule is based on the Ontario Society of Chiropodists and 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.

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN (If Applicable). I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE KAWARTHA FOOT & ORTHOTIC CLINIC 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 KAWARTHA FOOT & ORTHOTIC CLINIC. AS A GUARDIAN YOU ARE DECLARING TO BE THE GUARDIAN OF THE PATIENT.

ALL PERSONAL AND HEALTH INFORMATION IS KEPT CONFIDENTIAL.

Signature Patient or Guardian: _____ Date: _____