

HALTON FOOT CLINIC - PATIENT INTAKE FORM

First Name: _____ **Last Name:** _____ **Date of Birth:** _____
Address: _____ **City:** _____ **Postal Code:** _____
Cell Phone #: _____ **Home Phone #:** _____ **Email:** _____
Name of Insurance Provider(s): _____ **Occupation:** _____
Family Doctor's Name: _____ **Family Doctor's Phone #:** _____

Medical History

Describe the foot problem you are experiencing:

List all medical conditions that apply to you: (ie. Diabetes, High Blood Pressure, Cholesterol, etc.)

List all medications you are currently taking:

CHECK box if you are on blood thinning medications:

CHECK box if you are pregnant or breast-feeding:

List of all Allergies (Drugs, Food, Environment, etc.):

List any major surgeries, fractures and/or implants:

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

How Did You Hear About Us:

FEE SCHEDULE AND CONSENT

Foot care services in Ontario are NOT covered by OHIP. However we will provide you with all the necessary documentation for Extended Health Care Plans / Income tax health deduction purposes. Halton Foot & Orthotic Clinic's fee schedule is based on the OSC and the Canadian Federation of Podiatric Medicine's recommendations. Prices may change on an annual basis.

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE HALTON FOOT & ORTHOTIC CLINIC OR MY INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS. I CONSENT TO TREATMENT PERFORMED BY THE PRACTITIONERS OF THE CLINIC. IF YOU ARE A GUARDIAN, YOU ARE DECLARING TO BE THE LEGAL GUARDIAN OF THE PATIENT WITH YOUR SIGNATURE BELOW. ALL PERSONAL AND HEALTH INFORMATION WILL BE KEPT CONFIDENTIAL.

Patient or Guardian Signature:

Date: