

PATIENT INTAKE FORM

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

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

Date of Birth (DD/MM/YY): _____ **Email Address:** _____

Phone Number: Home _____ **Cell** _____ **Other** _____

Emergency Contact (Name and Phone Number): _____

Name of Insurance Provider: _____ **How Did You Hear About Our Clinic:** _____

Reason For Visit

Describe the foot problem you are experiencing:

Medical History

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

List all medications you are currently taking:

ARE YOU ON BLOOD THINNING MEDICATION? YES / NO

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

List any major surgeries, fractures and/or implants: _____

ARE YOU CURRENTLY PREGNANT? YES / NO

ARE YOU CURRENTLY BREAST-FEEDING? YES / NO

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

FEE SCHEDULE AND CONSENT

Foot care services in Ontario are NOT covered by OHIP. However we will provide you with 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 TREATMENTS PERFORMED BY THE PRACTITIONERS AT HALTON 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:** _____