Ashburnham Foot + Ankle Centre

GOOD HEALTH FROM THE GROUND UP

PATIENT INFORMATION FORM

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

Name (first and last): _____

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

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

Phone Number: Home_____ Cell_____ Other_____

Email Address: _____

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

Do you have extended health benefits? YES / NO
If "Yes", please list: ***Company:*** _____***Insured Member:***_____

Policy#: _____ ***Certificate#:*** _____

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

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

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

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

PLEASE CONTINUE TO THE NEXT PAGE

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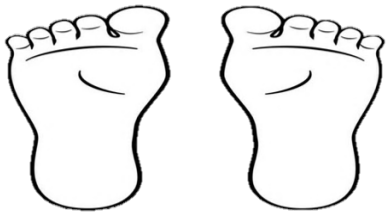
REASON FOR VISIT

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** ***(please circle)***
- **Skin Condition** _____
- **Circulatory Disorder:** _____
- **Tuberculosis**
- **Depression or Anxiety** ***(please circle)***

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:** _____

PLEASE CONTINUE TO THE NEXT PAGE

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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.***

No Show/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 will be subject to a $30.00 Fee. Surgery appointments not cancelled within 48 HOURS will be subject to a $50.00 fee.

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:** _____