Dalhousie Station Foot Clinic

INITIAL VISIT FORM

PATIENT INFORMATION

Last Name ____ First Name ____ M Initial ____ DOB (M/D/Y) ____ Age ____ Sex (M/F) ____ Alberta Health # ____

Street Address ____ City ____ Province ____ Postal Code ____ Home Phone ____

Employer____________________________ Occupation____________________________ Business Phone ____

Email Address______________________ (required for appointment related info only) Family Doctor________________________ Cell Phone ____

Have you ever been to another podiatrist, if so when?____

Insurance Provider: ____

What is the nature of your visit? (ie. foot pain, orthotics, etc.)______________________________________

How did you find out about us?

- ☐ Google/Yahoo/Bing
- ☐ Yellowpages.ca
- ☐ Referral by friend/family member______________________________
- ☐ Doctor Referral Letter (please specify) Dr.______________________
- ☐ Other (please specify) ______________________________________

GENERAL HEALTH

Weight_______________Shoe size____________Height_______________

Have you had an adverse reaction to dental freezing? NO____YES____If so, what was your reaction?________________

Any allergies? (ie penicillin) and your reaction (ie. rash, swelling)______________________________________

Have you ever smoked? NO___YES___If so, how many per day?________Did you quit? NO___YES___When?__________

	NO	YES
Do you get light-headed/anxious from needles?	_______	_______
Have you had a cortisone injection?	_______	_______
Are you subject to prolonged bleeding after cuts?	_______	_______

Do you currently or have in the past, worn custom orthotics? ______________________________________

What medications do you take regularly?____

Please list any past surgeries (foot or other):____

Please list any other health information we should know about__________________________________

CHECK ANY THAT APPLY:

Heart attack		Swelling of legs/feet		Rheumatoid arthritis		Cancer	
Angina (chest pain)		Varicose veins		Osteoporosis		Stomach Ulcer	
High blood pressure		Raynaud's disease		Back disorders		Prostate illness	
Low blood pressure		Numbness legs/feet		Neurological disorder		Lung disease	
Heart murmur		Stroke		Seizures		Asthma	
Irregular heartbeat		Anemia/Blood disorder		Kidney disease		Tuberculosis	
Poor circulation		Diabetes Mellitis		Liver disease/Hepatitis		Drug/Alcohol abuse	
Leg cramps		Osteoarthritis		HIV		Skin condition	

CONSENT FOR TREATMENT

I deem the above information to be true. I give permission to Dr. Russell of Dalhousie Station Foot Clinic to administer treatment and perform such procedures as maybe necessary in the diagnosis and/or treatment of my foot condition. I understand that podiatry is partially covered by Alberta Health Care. I agree to be financially responsible for all charges as related to my care.

- I understand that I am responsible for third party billing (insurance providers) arrangements required on my behalf. Dalhousie Station Foot Clinic will provide appropriate receipts or documentation for such claims.

- I understand that Dalhousie Station Foot Clinic does not accept Workers' Compensation Board (WCB) claims.

____

SIGNATURE OF PATIENT

or

____

SIGNATURE OF RESPONSIBLE PARTY/GUARDIAN

____

RELATIONSHIP TO PATIENT

____

DATE