



PATIENT INFORMATION

Last Name First Name Initial DOB (D/M/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 Referral by friend/family member
Yellowpages.ca 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?

Do you get light-headed/anxious from needles? NO YES

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:

Table with 7 columns and 11 rows listing medical conditions such as Heart attack, Swelling of legs/feet, Rheumatoid arthritis, Cancer, etc.

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