WATERLOO FOOT CLINIC

50 Westmount Rd. N Unit 215, Waterloo ON
519-884-3668

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ NICKNAME: _____

ADDRESS:	BIRTH DATE: DD/MM/YYYY
CITY:	AGE:
PROVINCE:	SEX: MALE FEMALE OTHER
PREFERRED PRONOUNS: SHE/HER HE/HIM THEY/THEM OTHER	
POSTAL CODE:	SHOE SIZE: LEFT__ RIGHT__

EMAIL: _____

APPOINTMENT REMINDER BY: **PHONE** or **EMAIL** or **TEXT** **(please circle preferences)**
HOME NUMBER: _____ CELL NUMBER: _____

OCCUPATION:	EMPLOYER:

INSURANCE PROVIDER: _____Plan & ID #:_____

MEDICAL HISTORY

FAMILY PHYSICIAN:_____ PHONE: _____

ADDRESS:_____

HEIGHT: _____ DO YOU SMOKE (IF YES, HOW MUCH & HOW OFTEN)? _____

WEIGHT:_____ DO YOU DRINK (IF YES, HOW MUCH & HOW OFTEN)? _____

MEDICATIONS	REASON FOR TAKING (IF KNOWN)

ARE YOU ON BLOOD THINNING MEDICATION? (PLEASE LIST ABOVE)

PLEASE CONTINUE FILLING OUT ADDITIONAL PAGES

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CURRENT OR PAST CONDITIONS		DETAILS
HIGH BLOOD PRESSURE	YES | NO	
HISTORY OF ULCERS	YES | NO	LOCATION:
COMMUNICABLE DISEASES (EX. HIV, HEPATITIS)	YES | NO	PLEASE LIST:
ARTHRITIS	YES | NO	LOCATION:
HEART PROBLEMS	YES | NO	PLEASE LIST:
STROKE	YES | NO	WHEN:
SKIN CONDITIONS (EX. PSORIASIS, ECZEMA)	YES | NO	PLEASE LIST:
MAJOR SURGERIES/HOSPITALIZATIONS	YES | NO	PLEASE LIST:
DIABETES	YES | NO IF YES, INDICATE TYPE:	NUMBER OF YEARS DIAGNOSED? CONTROLLED BY: · DIET · ORAL MEDICATION · INSULIN

ALLERGIES: _____

PLEASE LIST OTHER CONDITIONS NOT LISTED ABOVE: _____

_____

REASON FOR VISIT

PLEASE DESCRIBE THE FOOT PROBLEM YOU ARE EXPERIENCING: _____

_____

SELECTED CLINIC BECAUSE / REFERRED TO CLINIC BY: _____

EMERGENCY CONTACT

NAME: HOME PHONE:

RELATION: CELL PHONE:

PLEASE CONTINUE FILLING OUT ADDITIONAL PAGE

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Fee Schedule and Consent

Chiropody is not covered by OHIP. However, most **Third Party Insurance & Extended Health Care Plans** do cover Chiropody Services.

Your visits may also be eligible for income tax health deduction purposes.

Fee Schedule:

Waterloo Foot Clinics fee schedule is based on the Ontario Society of Chiropodists and the Canadian Federation of Podiatric Medicines recommendations. The fee schedule outlines common fees, however, does not encompass all treatments.

Therefore, *NOT all fees are displayed. Any additional fees will be discussed on an individual basis, and prices may change on an annual basis. Notifications will be made if there is a change in the fee schedule.*

Initial Consultation and Treatment	$70.00
Return visit and Treatment OR Therapeutic Appointment	$50.00
Return visit (Nailcare/treatment) PLUS Therapy	$60.00

We understand appointments may need to be cancelled. We appreciate you working with us and giving us 24 hours notification. A charge will be applied for any appointments not cancelled within 24 hours of the scheduled appointment.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician (if applicable). I understand that I am financially responsible for any balance. I also authorize waterloo foot clinic or my insurance company to release any information required to process my claims. I accept any charges associated with missed appointments.

Signature of Patient:_____ Date:_____

Signature of Parent or Guardian (If Applicable): _____