
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** (please circle preference)

HOME NUMBER: _____ CELL NUMBER: _____

OCCUPATION:	EMPLOYER:
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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)

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	NUMBER OF YEARS DIAGNOSED? CONTROLLED BY: <ul style="list-style-type: none"> · 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:

Fee Schedule and Consent

Chiropractic is not covered by OHIP. However, most **Third Party Insurance & Extended Health Care Plans** do cover Chiropractic 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 Chiropractors 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	\$65.00
Return visit and Treatment	\$43.00
Therapeutic Treatment	\$45.00
Custom Molded Prescription Foot Orthotics	\$450.00
Partial Nail Avulsion with Matrixectomy	\$350.00
Total Nail Avulsion with Matrixectomy	\$400.00
For each additional Toe at the same time	\$300.00
Local Anesthetic or Cortisone Injection	\$50-100
Soft Tissue Surgical Procedure	\$150-450

We understand appointments may need to be cancelled. We appreciate you working with us and giving us 24 hours notification.

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.

Signature Patient or Guardian: _____

Date: _____