Woodbine Foot Clinic
8787 Woodbine Ave, Unit 225
Markham, ON L3R 9S2
T 289 459 0255

New Patient Intake Form

Personal Information

Full Name: _____ Date of Birth: _____
First *Last* *Month/Day/Year*

Address: _____
Street Address *City* *Province* *Postal Code*

Home Phone: _____ Cell Phone: _____ Gender: _____

Email: _____ Height: _____ Weight: _____ Shoe Size: _____

How do you prefer to be contacted by us? ☐ Email ☐ Cell Phone ☐ Home Phone

Occupation: _____ Family Doctor: _____

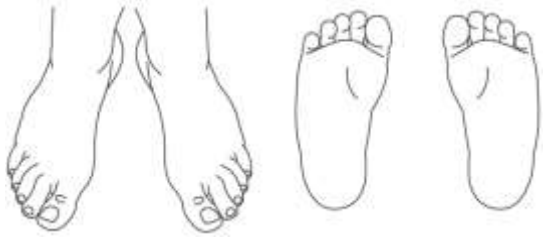
How did you hear about us: _____

Reason for your visit:

_____

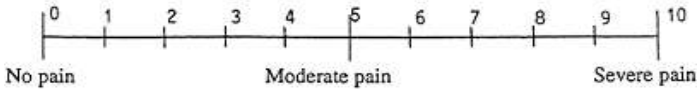
_____

_____



Please mark area(s) of pain on the above diagram

On a scale of 1-10,
please indicate the level of pain you're experiencing:



Medical History

Check all that apply now or have applied in the past:

☐Shortness of Breath ☐High Blood Pressure ☐Diabetes: type I type II ☐Arthritis
☐Asthma ☐Low Blood Pressure ☐Sensation loss/Numbness ☐Vision problems
☐COPD ☐Angina or Chest Pain ☐Sciatica ☐Headache/Migraines
☐Eczema ☐Heart Attack ☐Deep Vein Thrombosis ☐Osteoporosis
☐Psoriasis ☐High Cholesterol ☐Stroke/CVA ☐Gout
☐Thyroid problems ☐Circulation problems ☐HIV ☐Cancer
☐Others: ☐Hepatitis ☐Depression

_____

Previous Injuries: _____ Previous Surgeries: _____

Allergies: _____

Current Medications: _____

_____

Do you use any of the following? Please list type and frequency if applicable:

☐Alcohol: _____ ☐Smoke: _____ ☐Recreational Drugs: _____

Additional information: _____

_____

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Patient Consent

I _____, hereby request and consent to Chiropody treatment. I give the chiropodist, permission to perform necessary examinations and assessments, as well as diagnostic procedures as may be deemed necessary, in order to provide me with the best quality foot care.

I understand and am informed that, as in all health care, in the practice of Chiropody there are some slight risks to treatment, including, but not limited to pain, swelling, and infection. I do not expect the chiropodist to be able to anticipate and explain all the risks and complications and I wish to rely on the chiropodist to exercise judgment during the course of the procedure which the chiropodist feels at the time, based upon the facts then known, is in my best interest.

I further understand that I may withdraw my consent and request to terminate or modify the treatment at any time.

Fee Structure

I understand that chiropody services are ***not*** covered by OHIP, but are covered by most Third Party Insurance, Extended Health Care Plans, Veterans' Affairs, and/or can be used for income tax health deduction purposes. I authorize my insurance benefits be paid directly to the physician (if applicable). I understand I am financially responsible for any balance. I understand that payment in full is required after treatment and prices may be subject to yearly increase. I understand and agree to the fee structure posted in the reception area and explained to me by the staff.

Privacy Policy

The personal information collected is for limited and confidential use by the clinic. The information is not shared. Clinical record keeping will comply with legal and regulatory requirement of The College of Chiropodists of Ontario.

I have read the above consent. I have had the opportunity to ask questions about its content, and by signing below I agree to treatment by the chiropodist. I intend for this consent form to apply to the entire course of my treatment, including today and any other future visits.

Patient Signature: _____
Parent/Guardian (if patient is under 16)

Date: _____