Patient Information

Title ----------

First Name ----------

Surname ----------

Date of Birth ----------

Home Address

Street Address ----------

Address Line 2 ----------

City ----------

State / Province / Region ----------

Postal / Zip Code ----------

Country ----------

Home Phone ----------

Work Phone ----------

Mobile Phone ----------

Email ----------

Occupation ----------

Height ----------

Weight ----------

Shoe Size ----------

Relationship to patient ----------

How did you hear about our office?

Family Doctor .....

Doctor's Phone .....

Doctor's Address

Street Address .....

Address Line 2 .....

City .....

State / Province / Region .....

Postal / Zip Code .....

Country .....

Briefly describe any previous foot care (What, When, Where, Who)

Briefly describe current foot problem

Do you or have you ever experienced any of the following medical conditions and treatments?
(Please check all applicable)

- ☐ Heart Trouble
- ☐ Steroid Treatment
- ☐ Epilepsy
- ☐ Rheumatic Fever
- ☐ Excessive Bleeding
- ☐ Asthma
- ☐ Leg Cramps on Walking
- ☐ Hepatitis
- ☐ Psychiatric History
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ High/ Low Blood Pressure
- ☐ Anti-Coagulants
- ☐ Stroke
- ☐ Diabetes
- ☐ HIV
- ☐ Skin Conditions
- ☐ Varicose Veins
- ☐ Pregnancy
- ☐ Joint Replacement

Briefly describe any other relevant medical history

Allergies ----------

List all medicine you are currently taking: Prescription and over-the–counter medications (examples: aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko). Include medications taken as needed

For each medicine, please state the Prescription Medication or over-the-counter name, the does (how much), and the frequency (how often).

Conditions of treatment and payment

Payment and Private Health Insurance: I understand that insurance is a contract between me the insured and the insurance carrier, not between the insurance carrier and the Clinic and that I am responsible for payment. I acknowledge that the staff are willing to assist me in recovering my insurance entitlements. I realize that falsifying invoices is insurance fraud.

Privacy Policy: You have the right to read the Notice of Privacy Practices which provides a description of office treatment, payment activities and healthcare operations, of the uses and disclosures we may make to your protected health information, and other important matters about your protected health information. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

I have read the above conditions of treatment and payment and agree to their content. I hereby give the above named Clinic permission to administer the necessary examination in order to assess and treat my present foot condition, after it has been explained