FOOT CARE INSTITUTE

Today's Date: _____/_____/_____ File No.:_____
DD MM YYYY

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr

PATIENT'S NAME: _____
(FIRST) (MIDDLE) (LAST)

Gender: M☐ F☐ Date of Birth: _____/_____/_____
DD MM YYYY

Health Card No.: _____ Expiry Date: _____/_____/_____
DD MM YYYY

Address: _____
(STREET) (CITY) (POSTAL CODE)

Contact Phone No.: _____ Cell Phone No.:_____

Occupation: _____ Employer: _____

Email _____

Family Physician: _____ Date of Last Physical Exam: _____

Pharmacy Contact _____

What is your foot problem: _____

Have you had foot treatment before: ☐ Yes ☐ No

What treatment: _____ Where: _____

GUARDIAN NAME(if patient is a minor)/EMERGENCY CONTACT:

Name: _____ Relationship: _____

Contact Phone No.: _____

Address_____

How did you hear about our office? driving by☐ friend/family☐ referred by doctor☐
internet/Google☐ Facebook ☐ previous patient☐

(TURN PAGE OVER)

MEDICAL HISTORY

Medications (include prescriptions, over the counter medications and vitamins)

_____

_____

_____

ALLERGIES (CHECK ALL THAT APPLY):

☐ Aspirin
☐ Novocaine
☐ Codeine
☐ Demerol
☐ Penicillin
☐ Sulfa
☐ Mercurials
☐ Merthiolate
☐ Iodine
☐ Adhesives/Tapes
☐ Nylon/Plastic
☐ Antihistamines
☐ Sutures
☐ Others _____
☐ No allergies

I HAVE, OR HAVE HAD THE FOLLOWING (CHECK ALL THAT APPLY):

☐ anemia
☐ arthritis
☐ asthma
☐ bleeding tendencies
☐ blood clot
☐ blood pressure
☐ cholesterol
☐ cancer
☐ diabetes
☐ epilepsy
☐ glaucoma
☐ gout
☐ heart trouble
☐ kidney trouble
☐ leg cramps
☐ lung problems
☐ nervousness
☐ neuromuscular disease
☐ skin condition
☐ stroke
☐ stomach problems
☐ thyroid
☐ tumors
☐ tuberculosis
☐ varicose veins

Is there anything else we should know: _____

Are you pregnant: ☐ Yes ☐ No Shoe size _____ Height _____ Weight _____

Do you smoke: ☐ Yes ☐ No Amount: _____ Do you drink alcohol: ☐ Yes ☐ No Amount: _____

PRIVACY-PATIENT CONSENT

I have reviewed the information that explains how your office will use my personal information and the steps taken to protect my information. I know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that The Foot Care Institute can collect, use and disclose personal information about me as set forth in the information about the office's privacy policies.

Signature _____

Print Name _____

Date _____

Signature of Witness _____

CONSENT

1. I authorize treatment of the person named on the other side and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements promptly, upon presentation, unless credit arrangements are agreed upon with the Doctor of Podiatric Medicine.
2. It is agreed that payment will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon.
3. I certify that the above information is true and correct to the best of my knowledge. I hereby give permission to Millicent Vorkapich-Hill, DPM, and James W. Hill, DPM, (Doctors of Podiatric Medicine) to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet.

Please note that Millicent Vorkapich-Hill, and James Hill, are Doctors of Podiatric Medicine completing their degrees in 1993, and 1996 respectively. Millicent has been registered in Ontario as a podiatrist since 1993. However, according to the Chiropody Act of 1991, a cap was imposed in 1993 that currently does not allow any more Doctors of Podiatric Medicine to register as "podiatrists" in this province. Therefore, since James graduated after the cap was imposed, he is registered as a chiropodist in Ontario.

Signature of Responsible Party (PATIENT OR GUARDIAN) _____ Date: ____/____/____
DD MM YYYY

Thank You For Choosing Our Office!