New Tecumseth
Family Footcare
A Step Toward Better Health

Division of 1194466 Ontario Ltd.

New Patient Registration Form

Please Note: Any information provided by the patient will assist us in treating you safely and effectively. Feel free to ask any questions about the information being requested. Note that any information provided will be kept confidential unless your written permission allowed otherwise or required by law. The Rules of Civil Procedure in Ontario require that we produce, upon request, photocopies of the attending doctor's clinical notes and records, consultation notes, radiology reports, x-ray reports, and lab results that we may have in our possession. Your written permission will be required to release any information otherwise.

Please complete the following information:

Patient's Name: _____ Phone: (H) _____ (W) _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Sex: M F Height:_____ Weight:_____ Shoe Size:_____

Date of Birth: mm____dd____yy_____.

Occupation: _____ E-mail address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Health Benefits Insurance Provider: _____

Family Physician: _____ Phone: _____ Fax: _____

How were you referred to our office? _____

A personal referral is the highest compliment that a patient can give to their practitioner. If you have been referred by another patient you have the option of providing their name, so we can thank them with a referral appreciation certificate: _____

50 Main Street East, Unit 6B, Beeton, Ontario L0G 1A0
Tel: 905-729-0782 Fax: 905-729-4009

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Foot Health Information:

Please circle your selections below:

- Please describe your foot problem and what brings you to our office today? _____
  _____
- If you are having pain, how would you describe your pain?
  Sharp aching throbbing burning shooting electrical sensation Pins and needles
- How long has your problem been present?
  <3 days <7 days <3 weeks <6 weeks <6 months <9 months <1 year >1 year
- Sustained injury or accident, date of occurrence: mm____dd____yy____.
- Have you attempted any treatment to relieve your problem? Rest, elevation, OTC pads, ice, change in shoe styles, OTC medication (Tylenol, Advil, Motrin, etc), stretching, Other: _____
- Diabetes _____ yes/ no
- Respiratory (asthma, pneumonia, emphysema) _____ yes/ no
- Cardiovascular (heart attack, stroke, high blood pressure, poor circulation) yes/ no
- Thyroid _____ yes/ no
- Arthritis _____ yes/ no
- Skin Conditions (eczema, psoriasis) _____ yes/ no
- Neurological (stroke, numbness or tingling, loss of sensation) _____ yes/ no
- Cancer (present or history of) _____ yes/ no
- Gout _____ yes/ no
- Communicable Disease (Hepatitis, HIV) _____ yes/ no
- Previous Surgeries _____ yes/ no
- Hearing Loss _____ yes/ no
- Eye Conditions _____ yes/ no
- Other Conditions we should know about _____
- Injuries/Accidents _____ yes/ no
- Allergies (environmental, Medications) _____ yes/ no
- Smoker _____ yes/ no
- How much time do you spend on your feet each day: < 2hrs. < 4hrs. <7hrs. >7hrs.
- Have you worn or do you currently wear orthotics _____ yes/ no
- Knee, Hip, or Lower Back pain _____ yes/ no
- Sports/ Physical activities _____ yes/ no
- Sports/ Physical activities in the past _____ yes/ no
- List current Medications: _____

Patient Signature: _____ Date: _____

Chiropodist Signature: _____ Date: _____

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Office Policy - Please read carefully before signing

Chiropody Information and Fee Schedule:

- The practice of Chiropody is the assessment of the foot and the treatment and prevention of disease, disorders or dysfunctions of the foot by therapeutic, orthotic or palliative means and governed by the College.
- Chiropody services and orthotics are covered by many private health insurance plans, WSIB, and Veterans Affairs Canada. Chiropody services are not covered by OHIP, so please check your plan for details.
- Fees for Service, Orthotics and Footwear is based on the Canadian Federation of Podiatric Medicine and The Ontario Society of Chiropodists Fees Schedule and is subject to annual change.
- Sample of fees: Initial Assessment $26.50 plus Consultation or Treatment fee; Consultation, or Treatments starts at $54.75, Reassessment after 1 yr. or New Incident $25.75 plus treatment fee; Subsequent Visits; Cryosurgery Fee $17.75 single location plus treatment fee; Orthotics Fees: range $525-$565 per pair, includes case fee and warranty, please inquire for additional pairs; Compression legwear, Therapeutic Sandals or Prescription Orthopaedic/Therapeutic Footwear Fees vary (modifications extra), fees are subject to annual increases and may change without notice.

Appointment Policy:

- New Tecumseth Family Footcare is committed to providing you with the highest quality footcare and therefore, it is important that you keep your appointments.
- We will do our best to see you in a timely manner and ask that you please arrive five minutes before you scheduled appointment time to ensure your full allotted time and because it shows respect for other patients.
- Appointment times vary, so please inquire. We advise that you call ahead to schedule a time with the chiropodist as we are often booked in advance and may not be able to accommodate last minute appointments.
- We understand that sometimes events happen that require cancelling of your appointment and therefore a minimum of 48 hours' notice (Monday – Friday) must be given. Cancellation otherwise is considered a No-Show and repeated No-Show clinical appointments will lead to restrictions on advanced bookings and a No-Show fee.
- We reserve the right to refuse treatments to anyone not adhering to clinic policies or with an outstanding balance; the chiropodist may terminate or conclude the treatments or future treatments without a refund.

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PATIENT CONSENT FORM

I _____, hereby request and consent to Chiropody treatments. 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 consent to photographs to be taken by the Chiropodist and/or anyone working in this clinic authorized by the Chiropodist.

I hereby understand that Chiropody treatments are fee for service, and I am responsible for payment of all services and fees at the time of service. Payment is accepted in the form of cash, Debit, Visa and Master card.

I understand that all my personal information is confidential and will be used for no other purpose than for the Chiropodist's clinical records and to comply with legal and regulatory requirements of The College of Chiropodists of Ontario, Medical Physician, or Insurance Company regarding my file.

I understand and am informed that, as in all health care, in the practice of chiropody there are some very 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 risks and complications and I wish to rely on the Chiropodist to exercise judgement during the course of the treatment 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.

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's Signature: _____ Date: _____