Kapuskasing Foot Clinic

Name:_____
Date of birth:_____
Address:_____
_____

Phone number: home:_____ cell:_____ work:_____

Family Doctor:_____ phone:_____

Medical Insurance:___yes ____no.
If yes name of company:_____
Policy number:_____
Phone number:_____

Reason for appointment:

_____
_____
_____
_____

Are you currently taking any medications? If so please list them:

_____
_____
_____
_____
_____
_____

Do you have any medical conditions? Have you ever had any medical conditions?

_____
_____
_____
_____
_____

Have you ever had any surgeries? If so please list them:

_____
_____
_____

Have you ever fractured any bones, had any sprains?

Do you have any communicable diseases such as HIV/AIDS, Hepatitis, Tuberculosis or any others?

Do you have any allergies?

Do you have a bleeding disorder? _____

I hereby authorise the Chiropodist to perform treatment and or any procedures necessary in the assessment of my foot condition. I also understand that the cost of treatment provided is not covered under O.H.I.P. The fee however, may be covered under an Extended Health Care Plan.

Signature:_____ Date:_____